DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: KKYX
Facility ID: 00872

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245293**

2. STATE VENDOR OR MEDICAID NO. (L2) **417633200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - HOPKINS**
(L4) **725 SECOND AVENUE SOUTH**
(L5) **HOPKINS, MN** (L6) **55343**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **11/01/2002**

6. DATE OF SURVEY **01/03/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **138** (L18)

13.Total Certified Beds **138** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	138			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Gloria Derfus, Unit Supervisor — 01/31/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Enforcement Specialist — 3/6/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **10/01/1985** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00040** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245293

January 31, 2017

Ms. Talia Aramalay, Administrator
Golden LivingCenter - Hopkins
725 Second Avenue South
Hopkins, MN 55343

Dear Ms. Aramalay:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective December 13, 2016 the above facility is certified for:

138 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 138 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 23, 2017

Ms. Talia Aramalay, Administrator
Golden LivingCenter - Hopkins
725 Second Avenue South
Hopkins, MN 55343

RE: Project Number S5293027

Dear Ms. Aramalay:

On November 30, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 3, 2016 that included an investigation of complaint numbers H5293055 and H5293058. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 3, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 6, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 3, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 13, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 3, 2016, effective December 13, 2016 and therefore remedies outlined in our letter to you dated November 30, 2016, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245293		1/3/2017

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix F0157 Reg. # 483.10(b)(11) LSC	Correction Completed 12/13/2016	ID Prefix F0174 Reg. # 483.10(k),(l) LSC	Correction Completed 12/13/2016	ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 12/13/2016
ID Prefix F0246 Reg. # 483.15(e)(1) LSC	Correction Completed 12/13/2016	ID Prefix F0278 Reg. # 483.20(g) - (j) LSC	Correction Completed 12/13/2016	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 12/13/2016
ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 12/13/2016	ID Prefix F0311 Reg. # 483.25(a)(2) LSC	Correction Completed 12/13/2016	ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 12/13/2016
ID Prefix F0371 Reg. # 483.35(i) LSC	Correction Completed 12/13/2016	ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 12/13/2016	ID Prefix F0458 Reg. # 483.70(d)(1)(ii) LSC	Correction Completed 12/13/2016
ID Prefix F0465 Reg. # 483.70(h) LSC	Correction Completed 12/13/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GD/kfd	DATE 1/23/2017	SIGNATURE OF SURVEYOR 18623	DATE 1/3/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 11/3/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245293	A. Building 01 - MAIN BUILDING 01 B. Wing	1/6/2017

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0352	Correction Completed 12/13/2016	ID Prefix Reg. # NFPA 101 LSC K0712	Correction Completed 12/13/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 1/23/2017	SIGNATURE OF SURVEYOR 37009	DATE 1/6/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
11/1/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: KKYX
Facility ID: 00872

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245293**

2.STATE VENDOR OR MEDICAID NO.
(L2) **417633200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - HOPKINS**
(L4) **725 SECOND AVENUE SOUTH**
(L5) **HOPKINS, MN** (L6) **55343**

4. TYPE OF ACTION: **2** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **11/01/2002**

6. DATE OF SURVEY **11/03/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **138** (L18)
13.Total Certified Beds **138** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program
Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	138			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Magdalene Jares, HFE NE II 12/13/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/06/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
10/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00040
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 30, 2016

Ms. Talia Aramalay, Administrator
Golden LivingCenter - Hopkins
725 Second Avenue South
Hopkins, MN 55343

RE: Project Number S5293027

Dear Ms. Aramalay:

On November 3, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the November 3, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5293055 and H5293058.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 13, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 13, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by February 3, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 3, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. BUILDING ______ B. WING ______	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HOPKINS	**725 SECOND AVENUE SOUTH HOPKINS, MN 55343**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. During the recertification survey on 10/31/16, through 11/3/16, complaint investigation(s) were also conducted at the time of the standard survey. An investigation of complaint, H5293055 was completed. The complaint was substantiated. Deficiency(ies) issued at F157 and F174. An investigation of complaint, H5293058 was completed. The complaint was substanitated. Deficiency(ies) issued at F241, F312 and F465.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or	F 157		12/13/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 12/09/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident's representative was notified when medications changed and change in condition for 1 of 1 resident (R191) reviewed for notification of change. Findings include: R191's diagnoses included unspecified dementia without behavioral disturbance, hypothyroidism, acute kidney failure and repeated falls obtained from the Admission Record dated 4/26/16. During review of the interdisciplinary team (IDT)	F 157	Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in the Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations.	

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F 157 Continued From page 2

note dated 1/27/16, it was revealed resident had edema (swelling) on both lower extremities, some redness on the right inner thigh and resident had been started on a new order for Lasix 20 milligram (mg) by mouth every morning for three days for edema.

During review of the interdisciplinary team (IDT) progress notes dated 1/7/16, through 1/29/16, it was revealed the medical record lacked documentation the wife or legal representative had been notified of the change in condition and R191's new treatment plan.

R191's care plan dated 1/11/16, indicated resident had a diagnosis of Alzheimer's or related dementia, due to cognitive loss, had diminished decision making capabilities and as a result resident resided in the secured Alzheimer's Care Unit (ACU).

R191's cognitive loss/dementia Care Area Assessment (CAA) dated 1/20/16, indicated resident had dementia and had a supportive family.

On 11/3/16, at 7:28 a.m. licensed practical nurse (LPN)-C verified resident had been started on Lasix on 1/26/16, however the medical record lacked documentation the wife or the legal representative had not been notified of the treatment changes and the change in condition.

On 11/3/16, at 7:35 a.m. the director of nursing services (DNS) stated she would have expected the staff nurse to document resident family had been notified of any changes in treatment which included the medications. DNS verified the medical record lacked documentation the wife or

F 157

Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance.

The resident, R191, no longer resides at the facility.

For all residents residing in the facility the legal representative or an interested family member will be notified of any changes in resident condition or treatments.

The licensed nurses, the social workers and the registered dietician have been re-educated on the requirement to notify and document notification of changes in resident condition or treatment to the legal representative or interested family member when they occur.

Monitoring to ensure compliance will be conducted through random documentation audits to ensure that proper notification has taken place and been documented for changes in resident conditions and treatments.

The facility QAPI committee will review the documentation audits quarterly for further recommendations.

The date of completion will be 12-13-16.

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legal representative had been notified of the change in condition and treatment plan.

On 11/3/16, at 7:50 a.m. via a telephone conversation a family member stated they were not pleased with the care during the brief time R191 was in the facility. Family member indicated during one visit to the facility had noticed "his feet were swollen like a balloon. I think he needed Lasix. I was never notified of any medication changes." Family member indicated she was R191's legal representative and was supposed to be told.

The facility Notification of Change in Resident Health Status policy dated 10/12/16, directed "The center will consult the resident's physician, nurse practitioner or physician assistant, and if known notify the resident's legal representative or an interested family member when there is:
(A) An accident which results in injury and has the potential for requiring physician intervention.

Notification: Within 24 hours from the time as assessment has been made indicating there may be a potential for physician intervention.

(B) Acute illness or a significant change in the resident's physical, mental, or psychosocial status (i.e. deterioration in health, mental, psychosocial status in either life-threatening conditions or clinical complications.)

(C) A need to alter treatment significantly (i.e. a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment)..."

Your Rights Under The Combined Federal and

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F 157	Continued From page 4 Minnesota Residents Bill of Rights dated July 1, 2007, provided to resident and legal representative directed "14. Notice of Changes in Your Condition. The facility must consult with you immediately when there is an accident involving.	F 157		
F 174 SS=D	483.10(k),(l) RIGHT TO TELEPHONE ACCESS WITH PRIVACY §483.10(k) Telephone The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. §483.10(l) Personal Property The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to discharge resident with all personal property for 1 of 3 residents (R191). In addition failed to investigate and follow up on missing personal clothing for the same resident R191 when family contacted the facility. Findings include: R191's diagnoses included unspecified dementia without behavioral disturbance, hypothyroidism, acute kidney failure and repeated falls obtained from the Admission Record dated 4/26/16. During reviewed of the medical record dated 1/7/16, through 1/29/16, it was revealed on	F 174	The resident, R191, no longer resides in the facility. For all residents admitted to the facility a personal property inventory form will be completed. The personal property inventory form will be given to the resident, or resident's legal representative or interested family member to sign and a copy of the form will be placed in the medical record. Upon discharge from the facility the personal inventory form will be reviewed with resident, or resident's legal representative or interested family member to sign and ensure all personal belongings are accounted for. A copy of the signed personal inventory form will	12/13/16

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F 174	Continued From page 5 discharge from the facility to another facility on 1/29/16, the record lacked documentation R191 had been sent with all personal property/belongings. On 11/3/16, at 7:42 a.m. when asked if she had returned calls back to R191's family regarding the missing clothing, the Alzheimer's Care Unit (ACU) director stated she had left voice messages and had indicated she would bring back the other clothing that was not R191's. ACU director stated she had informed the wife she would be looking for the clothing and if she was not able to locate the clothing she had asked the wife to go buy the clothes then bring a receipt and the facility would be able to reimburse her. ACU director stated she had not heard from the wife since the voice messages. ACU director further stated the wife had brought back the clothing that did not belong to the resident however, ACU director verified the medical record lacked documentation of the telephone conversations and calls from the facility staff to R191's wife regarding the personal property issue and if the facility was looking or investigating the loss. When asked what the facility policy was on discharge if the staff was supposed to document belongs/personal property sent with resident/family ACU director stated she did not know. On 11/3/16, at 7:50 a.m. via a telephone conversation a family member stated she was not pleased with the care during the brief time R191 was in the facility. Family member indicated at the time of discharge the facility staff did not assist family in transferring resident into the vehicle and the family had to do it all which was difficult. Family member stated the clothing sent with resident did not belong to R191. Family member	F 174	then be placed in the medical record. Any discrepancies with personal property will be investigated and resolution of problem will be documented. Licensed social workers have been re-educated on the requirement to have the personal inventory forms be completed, reviewed and signed upon admission and discharge. The licensed social workers have also been re-educated on the requirement to investigate any discrepancies and document resolutions of discrepancies with personal belongings in the medical record. Monitoring to ensure compliance will be conducted through random chart audits for residents admitting and discharging from the facility. The facility QAPI committee will review the personal inventory chart audits quarterly for further recommendations. The date of completion will be 12-13-16.	

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F 174	Continued From page 6	F 174		

indicated she had made several telephone calls to the facility regarding the missing personal property pieces however, had never received any call back if the facility was looking for the missing items. Family member indicated she had brought back all the clothing sent with resident that did not belong to R191. Family member stated she had purchased resident clothing and shoes to replace the missing ones the facility had misplaced after she had identified the issue after R191 was admitted to another facility. When asked if the facility staff had called and informed her to bring a receipt for the facility to reimburse the missing items wife stated nobody had called or left any voice message. When asked if it was possible for her to bring the receipt wife stated R191's had recently passed away and she was in the process of grieving thanked for looking into the issue "am glad someone is looking into this."

On 11/3/16, at 8:16 a.m. ACU director reviewed the facility policy with surveyor and verified the policy indicated a form was to be filled.

R191's care plan dated 1/11/16, indicated resident had a diagnosis of Alzheimer's or related dementia, due to cognitive loss, had diminished decision making capabilities and as a result resident resided in the secured Alzheimer's Care Unit (ACU).

R191's cognitive loss/dementia Care Area Assessment (CAA) dated 1/20/16, indicated resident had dementia and had a supportive family.

Your Rights Under The Combined Federal and Minnesota Residents Bill of Rights dated July 1, 2007, provided to resident and legal

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F 174	Continued From page 7 representative directed "34. You have the right to retain and use personal possessions including some furnishings and appropriate clothing as space permits, unless it would infringe upon other resident's rights, health and safety. The facility must either maintain a central locked depository or provide individual locked storage areas in which you may store your valuables for safekeeping. The facility is responsible for reasonable preventive measures such as counseling you and your family members about the reasonable risks of brining valuable personal items into the facility, the desirability of labeling your belongings, have doors on all closets, and investigating incidents of loss or damage. The facility may, but is not required to, provided to, provide compensation for lost or stolen items..." The facility Discharge/Transfer of the Resident reviewed 8/29/16, directed staff: "7. Check belongings and inventory form-Have resident and/or representative or responsible care giver sign for belongings. a. Give copy to resident and/or representative. b. Place original in the medical record. 8. Escort resident in wheelchair out of facility unless transported via ambulance. Assist with belongings as necessary..."	F 174		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241		12/13/16

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to provide visual privacy for 1 of 3 residents (R44) reviewed for urinary incontinence.

Findings include:

During a random observation on 11/3/16, at 7:13 a.m. the door of the shower/tub room across from the nursing station was noted open. Nursing assistant (NA)-A requested something from licensed practical nurse (LPN)-D. Surveyor was able to see R44 seated on the toilet. R44's bare abdomen, left hip and left thigh were visible when standing outside the hallway. R44 was wearing a blue shirt pulled up and dark blue sweat pants were covering R44's feet lying on the floor in front of the toilet.

During observation on 11/3/16, at 9:45 a.m. R44 was brought to the shower/tub room across from the nurses' station. NA-A and NA-C verified there was no curtain around the toilet in the shower/tub room. At 9:51 a.m. NA-A and NA-c exited the shower room. Surveyor sitting at the nursing desk was able to see R44 sitting on the toilet. At 9:57 a.m. NA-A then entered the shower room and surveyor was able to see R44 sitting on the toilet with left side of body exposed.

R44's quarterly Minimum Data Set (MDS) dated 10/12/16, indicated R44 was severely cognitively impaired with verbal behaviors that affected others one to three days during the observational period. R44's MDS indicated R44 required assistance of two staff to use the toilet, and was frequently incontinent of bladder and always

The visual privacy for resident, R44, will be maintained for all toileting assistance. The privacy curtain will be in place and pulled to ensure visual privacy.
The visual privacy for all residents will be maintained for all toileting and personal cares by ensuring that privacy curtains are in place and utilized.
All nursing staff and therapists have been re-educated on the requirement to ensure visual privacy will be maintained for all residents when providing assistance with toileting and personal cares by utilizing privacy curtains.
All housekeeping staff have been re-educated on the requirement to promptly replace privacy curtains upon removal for cleaning.
Monitoring to ensure compliance will be conducted through random observational care audits to ensure the use of privacy curtains during personal cares. Weekly environmental audits be conducted to ensure privacy curtains are in place in required areas.
The facility QAPI committee will review the observational care audits and environmental audits quarterly for further recommendations.
The date of completion will be 12-13-16.

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F 241	Continued From page 9	F 241		

incontinent of bowel. In addition, R44's MDS indicated resident diagnoses included dementia and seizure disorder. R44's care plan dated 7/27/15, indicated R44 was incontinent of bowel and bladder and required assist of one to use the toilet.

During interview on 11/3/16, at 10:04 a.m. NA-A stated "we normally bring [R44] to the shower room because it is safer. [R44] can use the grab bars and can do the work himself." NA-A further stated, "There has never been a curtain around the toilet just in front of the shower. We try to be careful when we open the door but you can see into the room."

On 11/3/16, at 3:58 p.m. family member (FM)-B stated, "He would be upset if someone could see him in the bathroom. If he were aware that someone could see him, he would tell them to get lost and close the door."

During interview on 11/03/16, at 11:39 a.m. the director of nursing services (DNS) stated staff needed to maintain privacy for all residents. DNS further stated she was not aware that there was not a curtain in front of the toilet in the shower/tub room on the Alzheimer's unit as there had been one there.

The facility Incontinence Care policy reviewed 1/26/15, directed staff to "Drape resident for privacy."

The facility Dignity policy reviewed 3/31/16, indicated "All residents will be treated in a manner and in an environment that maintains and enhances each resident's dignity and respect in full recognition of his or her individuality. Treating

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F 241	Continued From page 10 residents with dignity and respect maintains and enhances each resident's self-worth and improves his or her psychosocial well-being and quality of life." Policy further instructed staff to maintain dignity by "Assisting residents in daily care in a dignified manner (e.g., pushing residents forward in wheelchairs, covering appliances attached to resident, ensuring residents are not exposed)."	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure call lights were within at reach for 2 of 4 residents (R74, R54) who were at risk for falls during random observations. Findings include: R74's annual Minimum Data Set (MDS) dated 10/3/16, indicated R74 had severely impaired cognition and was able to understand others and make his needs understood. R74's MDS indicated resident needed assistance with all activities of daily living and diagnoses included paraplegia (paralysis), arthritis and Alzheimer's.	F 246	The call lights are placed and are within reach for residents R74 and R54. The call lights will be placed and within reach for all residents residing in the facility. All nursing staff, housekeeping staff, social service staff and maintenance staff have been re-educated on the requirement to place and keep call lights within resident reach. Monitoring to ensure compliance will be conducted through random call light placement audits. The facility QAPI committee will review the call light placement audits quarterly for	12/13/16

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F 246	Continued From page 11	F 246	further recommendations. The date of completion will be 12-13-16.	

During a random observation on 10/31/16, at 7:22 a.m. R74's call light was observed down the back of the bed. Registered nurse (RN)-D verified that call light was not within R74's reach.

R74's fall Care Area Assessment (CAA) dated 10/18/16, indicated R74 was aware of what was being discussed but had problems with memory and recall.

R74's alteration in elimination bowel and bladder care plan dated 9/22/12, instructed staff to ensure call bell within reach and provide reminders to use call bell as needed. Fall risk care plan initiated 9/22/16 instructed staff to have call light or personal items available and in easy reach or provide reacher.

During interview on 10/31/16, at 7:22 a.m. RN-D stated R74 seldom used the call light.

During interview on 10/31/16 at 7:26 a.m. nursing assistant (NA)-F said "oh yes [R74] can use his call light."

R54's quarterly MDS dated 10/7/16, indicated R54 had moderately impaired cognition and was sometimes able to understand others and sometimes able to be understood. R54's MDS indicated R54 wanted an interpreter to communicate with health care staff. In addition the MDS indicated R54's diagnoses included low back pain, atrial fibrillation, depression and anxiety and needed assistance with all activities of daily living.

R54's vision CAA dated 1/25/16, indicated R54

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HOPKINS	**725 SECOND AVENUE SOUTH HOPKINS, MN 55343**

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F 246	Continued From page 12 was blind, had increased risk for falls and decline in activities of daily living. R54's care plan dated 1/22/15, indicated R54 was at risk for falls and instructed staff to have call light or personal items available and in easy reach. On 11/1/16, at 1:22 p.m. the director of social service (DSS) and surveyor entered R54 to set up an initial interview with R54 using the language line translator. DSS looked for the phone in R54's room but could not find it. DSS went and obtained a portable phone. R54's call light was observed lying on the floor next to R54's bed. R54 was lying in bed. DSS called R54's family on the phone and handed the phone to R54. DSS did not pick call light up and give it to R54. DSS had NA-F come to R54's room to see if R54 needed assistance. At 1:38 p.m. surveyor asked NA-F if R54 used the call light. NA-F verified R54 used the call light. NA-F did not check call light location prior to exiting the room. At 1:52 p.m. after completing interview with R54, surveyor put on the call light without moving it. NA-G answered the call light and verified call light was on the floor and out of R54's reach. NA-G gave the call light to R54. Call Light, Use of procedure reviewed 10/11/16, indicated the purpose was "to respond promptly to resident's call for assistance. To ensure call system is in proper working order. Procedure further instructs staff "when providing care to residents be sure to position the call light conveniently for the resident to use. Tell the resident where the call light was and show him/her how to use the call light. "Be sure all call lights are placed on the bed at all times, never on the floor or bedside stand.	F 246		
F 278	483.20(g) - (j) ASSESSMENT	F 278		12/13/16

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F 278 SS=D	Continued From page 13 ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the Minimum Data Set (MDS) was correctly coded for 1 of 2 (R48) residents reviewed for dental. Findings include:	F 278	The MDS for resident R48 has been corrected to accurately reflect the dental status. The MDS assessment for all residents will accurately reflect their dental status. The MDS nurses have been	

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F 278	Continued From page 14 R48 admission MDS dated 6/3/16, indicated R48 had severely impaired cognition and was able to eat independently after set up by staff. R48's MDS indicated R48's diagnoses included coronary artery disease, diabetes and Alzheimer's. In addition the MDS indicated R48 did not have any dental issues During observation on 11/1/16, at 2:30 p.m. R48 was noted with no teeth or dentures in his mouth. During interview on 11/2/16, at 1:51 p.m. registered nurse (RN)-D verified R48 did not have teeth or dentures. -At 2:16 p.m. licensed practical nurse (LPN)-C reviewed prior facility discharge paper work and admission assessment and stated "I know what it says but he did not come here with dentures." On 11/2/16, at 2:21 p.m. RN-E, director of resident assessment reviewed R48's admission MDS and documentation in chart. RN-E stated, "If you mark it none of the above were present that means he has teeth or dentures. His MDS is marked none of the above, making you think he has dentures or teeth. The transfer summary indicated he has upper and lower teeth. The admission assessment indicates no teeth and does not address dentures. The nutrition note is within our reference period. I guess my MDS is not accurate. If it [MDS] had been coded correctly it would have triggered a CAA and I would have had to address the issue." RN-E further stated, the care plan would address diet, direct staff to check for lesions, dry mouth, and infections that may be caused by oral infections. During interview on 11/3/16, at 1:44 p.m. the	F 278	re-educated on the requirement to correctly code the dental status of each resident and complete the dental CAA as indicated. The education will include the requirement to ensure data is derived from the nursing and dietician assessments. Monitoring to ensure compliance will be accomplished through random MDS audits for accuracy in the coding of the dental status. The facility QAPI committee will review the MDS audits quarterly for further recommendations. The date of completion will be 12-13-16.	

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Alzheimer's care unit director (ACUD) stated, "We did not do dental referral or have her [guardian] sign a dental form when [R48] was admitted." The guardian told me R48 was not able to get dentures." ACUD acknowledged, "I did not document that conversation."

During document review the following were revealed:
-Discharge summary from previous facility dated 5/27/16, indicated R48 had upper and lower dentures at time of discharge. Copy of discharge summary requested but not received.
-Clinical Health Status form dated 5/27/16, indicated R48 had "No teeth" and did not address presence of dentures.
-Nutrition Data sheet dated 6/3/16, indicated R48 had Swallowing disorder and chewing problems, "no teeth -has dentures, but claims they broke." Nutritional assessment dated 6/3/16, indicated R48 did not have teeth and R48 had reported dentures were broken. Dietician charted leaving a message for the director of Alzheimer unit to see if R48 could get an appointment with dentist to get dentures fixed,
- R48's MDS dated 6/3/16, Section L- oral dental status part 0200b, was not marked indicating, "No natural teeth or tooth fragments (edentulous)." R48 did not have a dental CAA completed.

The facility RAI (resident assessment instrument) Process Policy dated 8/20/15, indicated, "All Living Centers will utilize the CMS [Centers for Medicare and Medicaid Services] RAI Manual for completion and compliance of the RAI process"

The RAI manual dated October 2016, the ability to chew food was important for adequate oral nutrition. Having clean and attractive teeth or

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F 278	Continued From page 16 dentures can promote a resident's positive self-image and personal appearance, thereby enhancing social interactions. Medical illnesses and medication-related adverse consequences may increase a resident's risk for related complications such as impaired nutrition and communication deficits. The dental care CAA addressed a resident's risk of oral disease, discomfort, and complications.	F 278		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the plan of care was implemented for shaving for 1 of 3 residents (R28) reviewed for activities of daily living (ADLs), failed to assist 1 of 2 residents (R52) to the toilet in accordance with their toileting plan, and failed to prevent non-pressure related skin break down related to lack of repositioning and shearing for 1 of 4 residents (R52) reviewed for wheelchair positioning. Findings Include: R28 was observed on 10/31/16 at 1:42 p.m., to have black facial hair on the right edge of her mouth. On 11/1/16, at 12:23 p.m. the black facial hair remained on the right side of R28's mouth.	F 282	The resident, R28, has had facial hair removed. The resident, R52, has received toileting and repositioning in accordance with plan of care. The non-pressure skin alteration for resident, R52 has resolved. All residents residing in the facility will have facial hair removed unless resident preference states otherwise. All residents will be toileted and repositioned in accordance with the plan of care. All nursing staff have been re-educated on the requirement to remove facial hair from all residents unless resident preference states otherwise. All nursing staff have been re-educated on the requirement to toilet and reposition all residents in accordance with the plan of care.	12/13/16

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On 11/3/16, at 7:19 a.m. nursing assistant (NA)-C was observed to assist R28 with adl's. NA-C changed R28's incontinence product, then assisted R28 to get dressed, wash face and comb the resident's hair. NA-C then took R28 to a table in the small dining room for breakfast. At that time, R28 was observed to have eight black 1/2 inch long hairs on the right side of her mouth.

On 11/3/16, at 9:05 a.m. NA-C was obsesrved to provide person hygiene care, incontinence care for R28. The NA did not identify or assist R28 with removal of the black 1/2 inch hairs on the right side of her mouth.

R28's care plan identified interventions for staff to assist R28 with personal hygiene.

During interview on 11/3/16, at 7:21 a.m. when R28 was asked about facial hair, R28 replied, "A lady does not have facial hair. Do I have facial hair?"

During interview on 11/3/16, at 9:58 a.m. NA-C said, "She accepts and appreciates help. I did not shave her today. I was so busy. She has a little mustache. I normally shave her after one to two days depending on the beard. We are to look every morning when she gets up and shave her if needed. I should have done so today."

R52 was observed on 11/2/16, at 7:20 a.m. in the dining room reading the newspaper. R52 was slouched part way down in Broda chair, with knees above the top of the table. R52's hips were at approximately 45 degree angle with knees higher than hips. R52's feet were on foot pedals. Additional observations on 11/2/16 included:
-7:30 a.m. the director of nursing services (DNS)

F 282

Monitoring to ensure compliance will be conducted through weekly grooming audits and weekly observational audits of toileting and repositioning to ensure accordance to the plan of care.

The facility QAPI committee will review the grooming and the observational toileting and repositioning audits quarterly for further recommendations.

The date of completion will be 12-13-16.

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F 282	Continued From page 18 walked through the dining room and spoke with other residents. -7:32 a.m. nursing assistant (NA)-A offered R52 a clothing protector. NA-A did not adjust R52's wheelchair positioning. -7:44 a.m. registered nurse (RN)-K with Asera Care hospice took R52 out of the dining room. -7:55 a.m. RN-K returned R52 to the dining room table and gave R52 a magazine. R52's knees remained higher than the table top. -8:14 a.m. R52 pushed himself-back from the dining room table. -8:21 a.m. RN-K checked R52's foot rest and adjust his feet. -8:24 a.m. Breakfast meal was placed in front of R52. NA-A adjusted R52's chair so R52's knees were not above the table top. -9:03 a.m. licensed practical nurse (LPN)-D wheeled R52 to the small dining room and positioned him at a table. R52 was positioned upright at the table with both knees lying to the left the table top. - 9:05 a.m. R51. RN-D reclined Broda chair part way without telling R52 she was going to recline him. R52's eyes went wide open and R52 opened his mouth wide and upper body stiffened. RN-D wheeled R52 to the main dining room. -9:54 a.m. R52 was sitting in Broda chair at table playing cards by his self. R52 was sliding part way down in chair. The Broda chair was in an upright position. -10:52 a.m. R52 sitting in chair playing cards. Position unchanged with R52 slouched down in the chair. -10:55 a.m. activities assistant-A moved R52 to the parachute group and had R52 hold on to strap of the parachute. -11:16 a.m. LPN-C was interviewed as to how frequently R52 was to be toileted and	F 282		

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F 282	Continued From page 19	F 282		

repositioned out of the Broda chair. LPN-C said, "[R52] gets checked and changed every two hours I will have to ask the nursing assistants when he was last changed."
- 11:23 a.m. LPN-C said, "[NA-B] is at lunch. I am going to have it done right now since I assume it should have been done. They should have done it after breakfast."
-11:27 a.m. NA-A brought R52 to room and left room to locate a lift and sling.
-11:28 a.m. surveyor obtained R52's permission to observe cares.
-11:30 a.m. NA-A returned and said needed to wait for a lift as they only had one lift.
-11:34 a.m. LPN-C entered room and obtained permission to observe cares
-11:36 a.m. NA-A and NA-B entered with mechanical lift.
-11:38 a.m. NA-A and NA-B left to get EZ stand because R52 was an EZ stand transfer.
-11:39 a.m. NA-A and NA-B washed hands and put gloves on. NA-A explained to R54 what they were doing. NA-A and NA-B put on EZ stand belt and lifted R52 to a standing position and took R52 into the bathroom. NA-B pulled down R52's pants and removed the soiled incontinent brief. NA-B indicated the pad was very wet with urine. NA-A and NA-B lowered R52 to the toilet seat and washed their hands. Staff exited the bathroom to allow R52 privacy.
- 11:48 a.m. NA-B said, "I have not noticed him sliding down in the chair. I have not toileted him since before breakfast he is to be toileted every two hours.
-11:49 a.m. LPN-C checked R52's bottom when he was standing in the EZ Stand. Red bloody area noted on scrotum. LPN-C asked NA-A and NA-B to put R52 in bed and then go get RN-D to assess and measure the wound.

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F 282	Continued From page 20 At 11:57 a.m. RN-D measured the wound on R52's scrotum and stated it was 1.5 centimeters (cm.) long by x 0.5 cm. wide. RN-D said the depth was too shallow to measure. RN-D and LPN-C said that was a new wound and they were going to call it a Stage two pressure ulcer (Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister) due to prolong sitting and R52 sliding in the Broda chair. R52's OT-Therapist Progress & Discharge Summary dated 7/29/15, indicated, "Provided caregiver education on recommendations for wch [wheelchair] in upright alignment, Repositioning of hips in wch every 1-2 hours due to pt [patient] unable to initiate secondary to cognitive impairment and recommendation for leisure activities out in front of pt on tables to reduce agitation." R52's Swallowing Difficulty as related to Abnormal Swallow study care plan dated 10/6/15, instructed staff to ensure proper positioning at meals. R52's self-care deficit care plan instructed staff on 9/21/16, to toilet R52 every two hours. During the survey process alteration in skin integrity related to impaired physical mobility, bowel and bladder incontinence presence of scrotal edema and at risk for scrotum shearing care plan were initiated. R52's significant change of condition Minimum Data Set (MDS) dated 9/6/16, indicated R52 had both short and long term memory problems and diagnoses of dementia, osteoarthritis, hemiplegia (loss of movement on one side of the body) and failure to thrive. R52's MDS indicated R52 required assistance with dressing toileting,	F 282		

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F 282	Continued From page 21	F 282		

transfers and bed mobility and was always incontinent of bowel and bladder. R52's MDS identified R52 was at risk for skin breakdown and skin was intact.

The Treatment Administration Record dated 11/1/16 through 11/30/16, indicated R52 was to be repositioned every two hours and as needed. The date of the order was 4/9/15.

During an interview 11/2/16, at 2:03 p.m. LPN-C said, "We reassessed the wound with the assistant director of nursing (ADNS) and the wound is caused by shearing and is not a pressure ulcer. The treatment will be barrier cream, off loading/reposition every hour. I have ordered a low air loss mattress. We believe the shearing was caused when they transferred [R52] with the EZ stand." LPN-C said "We did considered the sliding in the Broda chair and high knees as possible causes of shearing and have requested hospice have their Physical Therapist evaluate him for positioning."

During interview on 11/3/16, at 10:04 a.m. NA-A said, "[R52] tries to move sometimes when he is in pain or is wet. If he was at the table with his knees above the table we should have sat him up after we boosted him up in the chair."

During interview with DNS and ADNS on 11/3/16, at 11:39 a.m. DNS said they met with NA-B and NA-B had admitted he had missed checking R52 when he should have. The DNS said, "He felt it was not deliberate but I did report it to OHFC (the Office of Health Facility Complaints) and suspended NA-B until we complete the investigation, because it could be construed as neglect under the vulnerable adult act. The ADNS

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F 282	Continued From page 22 said, "I went and reassessed with our RN clinical educator and LPN-C. We reassessed R52 right after lunch. The RN clinical educator and I determined it looked more like a shearing traumatic injury. R52 is in a reclining wheel chair and his scrotum is quite edematous and large." The ADNS said, "He slid down during the transfer and then standing with the standing lift. Because it was such frank blood we feel it occurred during the transfer." The DNS also confirmed the ADNS is not wound certified nor is the RN clinical educator. The DNS stated she expected staff to ensure residents would be positioned properly and would not be sliding repeatedly or leaning in their wheelchairs. The DNS further stated she expected staff to ensure residents were sitting upright while eating. During interview on 11/3/16, at 1:29 p.m. LPN-D said, "R52 sits forward a lot. He almost looks like he is trying to pull himself forward." During interview on 11/3/16, at 4:29 p.m. occupational therapist (OT)-B said hospice usually provided the Broda chairs. OT-B also stated therapy had seen R52 in July of 2015, for positioning. "We recommended frequent repositioning of hips as needed." OT-B said, "It would not be appropriate to have R52's knees above the table."	F 282		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309		12/13/16

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F 309	Continued From page 23 and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 4 of 4 residents (R56, R52, R21, R100) were appropriately evaluated for wheelchair positioning needs reviewed for positioning. In addition, the facility failed to ensure 1 of 4 residents (R52) maintained intact skin. Findings include: R56's diagnoses included vascular dementia, major depressive disorder, hemiplegia and hemiparesis obtained from the Admission Record dated 11/3/16. R56's quarterly Minimum Data Set (MDS) dated 5/18/16, indicated resident had both short and long term memory problems, had functional limitation of range motion to both lower extremities and used a wheelchair for mobility. Activities of daily living Care Area Assessment (CAA) dated 12/15/15, indicated R56 needed total assistance for transfers and locomotion due to dementia, impaired balance and history of cerebrovascular accident (CVA) with mobility deficits. Care plan dated 8/13/16, indicated R56 was at risk for physical functioning deficit related to cognitive impairment related to secondary vascular dementia. The care plan indicated resident used a wheelchair and staff was to keep the wheelchair in a reclined position until food was served at all meals. The care plan however, did not address the wheelchair positioning.	F 309	The residents, R56, R52, R21 and R100 have been evaluated for wheelchair positioning needs and adjustments have been put into place as required. All residents residing in the facility will be evaluated for wheelchair positioning on a quarterly basis and as needed to ensure proper wheelchair positioning. Therapy staff have been re-educated on the requirement to conduct quarterly wheelchair positioning evaluations. All nursing staff have been re-educated on the requirement to observe resident wheelchair positioning and take note of improper positioning which would include improper body alignment, dangling of feet, sliding in chair, reclined seating at meals in conjunction with improper table heights. Monitoring to ensure compliance will be conducted through random observational wheelchair positioning audits. The facility QAPI committee will review the wheelchair positioning audits quarterly for further recommendations. The date of completion will be 12-13-16.	

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GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

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On 11/2/16, at 7:20 a.m. R56 was observed in the large dining room slouched part way down in high back tilt in space wheelchair. R56's body angled from left to right with legs dangled to right side off wheelchair.
-At 7:30 a.m. the director of nursing services (DNS) walked through the dining room adjusted R56's glasses, spoke briefly to resident and left never offered to adjust resident position.
-At 7:32 a.m. nursing assistant (NA)-A approached resident at the dining table offered a clothing protector however, never offered to adjust resident position even though the legs were still dangling.
-At 7:44 a.m. to 8:06 a.m. resident remained in the same position seated on wheelchair several staff in the area none offered to position resident.
-At 8:20 a.m. R56 was still sitting angled left to right feet dangling off the right side of wheelchair and a plate of food was in front resident on the table.
-At 8:29 a.m. NA-A and NA-B approached resident pulled resident chair back from table, cued resident then reclined wheelchair and lifted resident up in the wheelchair with a hand under arm and knee on each side. During the observation, the wheelchair was set back up footrest was not extended and resident feet were dangling.
-At 8:55 a.m. NA-A approached R56 reclined the Broda wheelchair to a 45 degrees angle then put the footrest down, put resident feet on it and wheeled resident out of room in a 45 degree reclining.
-At 9:38 a.m. resident was observed asleep at the end of the hall across from small dining room reclined at 45 degrees legs dangling off to the right and registered nurse (RN)-D walked past

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resident never offered to re-position resident.
-At 9:43 a.m. the activities assistant walked past resident never offered to re-position.
-At 9:43 a.m. licensed practical nurse (LPN)-C approached R56 and offered resident to go to bed. LPN-C stated she was going to adjust feet however left the feet still dangling and resident hips were observed off center to the right.
-At 9:51 a.m. LPN-C returned with NA-A and NA-D wheeled resident into the room.

On 11/3/16, at 9:17 a.m. R56 was observed seated on the Broda wheelchair in the room watching television. The wheelchair was slightly tilted at approximately 30 degrees, and resident bottom was slumped down on the wheelchair seat close to the edge, legs hanging to the right side of the folded footrest.
-At 9:20 a.m. NA-A and NA-C came into the room acknowledged resident was sliding out of the wheelchair and indicated that was why they needed to lay resident down. Both NA's indicated resident always did slide down the wheelchair and the nurses knew about it and thought the facility had tried three different wheelchairs with resident however still was sliding down.

On 11/3/16, at 9:34 a.m. the occupational therapist (OT)-A reviewed the medical record and indicated the last time resident had been seen by OT-A was in 8/10/16, for a broken wheelchair. OT-A verified there was no notes or order were in the medical record for the need to do a full assessment for proper positioning.

On 11/3/16, at 3:47 a.m. the director of rehabilitation stated resident was discharged from occupational therapy last in 10/20/14, and was on the same wheelchair and the recommendation

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was to reposition as needed and staff was to lay resident down if restless. The director of rehabilitation indicated, "we do quarterly screens to identify a change and if we identified a significant change we then would ask the doctor for orders to treat [R56]." The director of rehabilitation further stated she was not able to locate the quarterly screening for R56 from March this year however was going to check with medical records.

On 11/3/16, at 4:18 p.m. LPN-C state R56 had been seen for a broken wheelchair armrest not positioning. LPN-C acknowledged R56 did dangle his feet on the side and stated the staff were supposed to reposition resident. LPN-C verified the care plan did not address the positioning and stated she would be obtaining an order for occupational therapy to evaluate R56 for positioning.

On 11/3/16, at 4:45 p.m. the director of rehabilitation verified there was no quarterly occupational therapy screens completed for R56 for wheelchair positioning. She indicated moving forward she would ensure quarterly screens were done consistently to make sure the residents were properly positioning in the wheelchairs.

R52 was observed on 11/2/16, at 7:20 a.m. and was in the dining room reading the newspaper. R52 was slouched part way down in Broda chair, with knees above the top of the table top. R52's hips were at approximately 45 degree angle with knees higher than hips. R52's feet were on foot pedals.
-7:30 a.m. the DNS walked through the dining room and spoke with other residents and did not adjust R52's wheelchair positioning.

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F 309	Continued From page 27 -7:32 a.m. NA-A offered R52 a clothing protector. NA-A did not adjust R52's wheelchair positioning. -7:44 a.m. registered nurse (RN)-K with Asera Care hospice took R52 out of the dining room. -7:55 a.m. RN-K returned R52 to the dining room table and gave R52 a magazine. R52's knees were higher than the table top. -8:14 a.m. R52 pushed self-back from dining room table. -8:21 a.m. RN-K checked R52's foot rest and adjust his feet. -8:24 a.m. Breakfast was placed in front of R52. NA-A adjusted R52's chair so R52's knees were not above the table top. -9:03 a.m. LPN-D wheeled R52 to the small dining room and positioned him at a table. R52 was positioned upright at the table with both knees lying to the left the table top. - 9:50 a.m. RN-D reclined Broda chair part way without telling R52 she was going to recline him. R52's eyes went wide open and R52 opened his mouth wide and upper body stiffened. RN-D wheeled R52 to the main dining room for an activity. -9:54 a.m. R52 was sitting in Broda chair at table playing cards by his self. R52 was sliding part way down in chair. The Broda chair was in an upright position. -10:52 a.m. R52 sitting in chair playing cards and the position was unchanged as R52 was slouched down in the chair. -10:55 a.m. activities assistant-A moved R52 to the parachute group and had R52 hold on to strap of the parachute. -11:16 a.m. LPN-C was interviewed as to how frequently R52 was to be toileted and repositioned out of the Broda chair. LPN-C said, "[R52] gets checked and changed every two hours I will have to ask the nursing assistants	F 309		

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F 309	Continued From page 28 when he was last changed." -11:27 a.m. NA-A brought R52 to room and left room to locate a lift and sling. -11:30 a.m. NA-A returned and said needed to wait for a lift as they only had one lift. -11:36 a.m. NA-A and NA-B entered with a mechanical lift. -11:38 a.m. NA-A and NA-B left to get EZ stand because R52 was an EZ stand transfer. -11:39 a.m. NA-A and NA-B washed hands and put gloves on. NA-A explained to R52 what they were doing. NA-A and NA-B put on EZ stand belt and lifted R52 to a standing position and took R52 into the bathroom. NA-B pulled down R52's pants and removed the soiled incontinent brief. NA-B indicated the pad was very wet. NA-A and NA-B lowered R52 to the toilet seat and washed their hands. Staff exited the bathroom to allow R52 privacy. -11:49 a.m. LPN-C checked R52's bottom when he was standing in the EZ Stand. There was a red bloody area noted on scrotum. LPN-C asked NA-A and NA-B to put R52 in bed and then go get RN-D to assess and measure the wound. At 11:57 a.m. RN-D measured the wound on R52's scrotum and stated it was 1.5 centimeters (cm.) long by x 0.5 cm. wide. RN-D said the depth was too shallow to measure. RN-D and LPN-C said that was a new wound and they were going to call it a stage two pressure ulcer (partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present) due to prolong sitting and R52 sliding in the Broda chair.	F 309		

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R52's significant change of condition MDS dated 9/6/16, indicated R52 had both short and long term memory problems and diagnoses of dementia, osteoarthritis, hemiplegia (loss of movement on one side of the body) and failure to thrive. R52's MDS indicated R52 required assistance with dressing toileting, transfers and bed mobility and was always incontinent of bowel and bladder. R52's MDS identified R52 was at risk for skin breakdown and skin was intact.

R52's urinary incontinence CAA dated 4/15/16, indicated R52 was dependent on staff for toileting and was at risk for moisture related skin break down. The pressure ulcer CAA dated 4/15/16, indicated R52 was at risk for worsening skin break down and pressure ulcers. The Care Area Assessment for the most recent comprehensive MDS dated 9/6/16, were requested but not provided.

R52's Swallowing Difficulty as related to Abnormal Swallow study care plan dated 10/6/15, instructed staff to ensure proper positioning at meals. R52's self-care deficit care plan instructed staff on 9/21/16, to toilet R52 every two hours. During the survey process, the alteration in skin integrity related to impaired physical mobility, bowel and bladder incontinence, and the presence of scrotal edema and at risk for scrotum shearing care plan were initiated.

The Treatment Administration Record dated 11/1/16 through 11/30/16, indicated R52 was to be repositioned every two hours and as needed. The date of the order was 4/9/15.

The OT-Therapist Progress & Discharge Summary dated 7/29/15, indicated, "Provided

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F 309	Continued From page 30 caregiver education on recommendations for wch [wheelchair] in upright alignment, Repositioning of hips in wch every 1-2 hours due to pt [patient] unable to initiate secondary to cognitive impairment and recommendation for leisure activities out in front of pt on tables to reduce agitation." During interview on 11/02/16 at 11:23 a.m. LPN-C said, "[NA-B] is at lunch. I am going to have it done right now since I assume it should have been done. They should have done it after breakfast." During interview 11/2/16, at 11:48 a.m. NA-B said, "I have not noticed him sliding down in the chair. I have not toileted him since before breakfast he is to be toileted every two hours. During interview 11/2/16, at 2:03 p.m. LPN-C said, "We reassessed the wound with the assistant director of nursing (ADNS) and the wound is caused by shearing and is not a pressure ulcer. The treatment will be barrier cream, off loading/reposition every hour. I have ordered a low air loss mattress. We believe the shearing was caused when they transferred [R52] with the EZ stand." LPN-C said "We did considered the sliding in the Broda chair and high knees as possible causes of shearing and have requested hospice have their physical therapist evaluate him for positioning." During interview on 11/3/16, at 10:04 a.m. NA-A said, "[R52] tries to move sometimes when he is in pain or is wet. If he was at the table with his knees above the table we should have sat him up after we boosted him up in the chair."	F 309		

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During interview with DNS and ADNS on 11/3/16, at 11:39 a.m. DNS said they met with NA-B and NA-B had admitted he had missed checking R52 when he should have. The DNS said, "He felt it was not deliberate but I did report it to OHFC (the Office of Health Facility Complaints) and suspended NA-B until we complete the investigation, because it could be construed as neglect under the vulnerable adult act. The ADNS said, "I went and reassessed with our RN clinical educator and LPN-C. We reassessed R52 right after lunch. The RN clinical educator and I determined it looked more like a shearing traumatic injury. R52 is in a reclining wheel chair and his scrotum is quite edematous and large." The ADNS said, "He slid down during the transfer and then standing with the standing lift. Because it was such frank blood we feel it occurred during the transfer." The DNS also confirmed the ADNS is not wound certified nor is the RN clinical educator. The DNS stated she expected staff to ensure residents would be positioned properly and would not be sliding repeatedly or leaning in their wheelchairs. The DNS further stated she expected staff to ensure residents were sitting upright while eating.

During interview on 11/3/16, at 1:29 p.m. LPN-D said, "R52 sits forward a lot. He almost looks like he is trying to pull himself forward."

During interview on 11/3/16, at 4:29 p.m. occupational therapist (OT)-B said hospice usually provided the Broda chairs. OT-B also stated therapy had seen R52 in July of 2015, for positioning. "We recommended frequent repositioning of hips as needed." OT-B said, "It would not be appropriate to have R52's knees

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above the table."

R21's quarterly MDS dated 8/1/16, indicated R21 was severely cognitively impaired, sometimes understood others, and was dependent on staff for transfers, bed mobility, dressing, toileting, personal hygiene and wheel chair mobility. R21 required supervision when eating. R21's MDS indicated R21's diagnoses were dementia, chronic kidney disease, depression, anxiety, chronic obstructive pulmonary disease and experienced coughing/choking during meals. R21 was on hospice.

Pressure Ulcer CAA dated 2/25/16, indicated R21 required assistance with transfers and wheelchair mobility needed a special seat cushion in wheelchair to reduce or relieve pressure

Pressure ulcer actual or at risk care plan printed 11/3/16, instructed staff to provide pressure reducing wheelchair cushion and turning and repositioning per assessment. Potential for impaired physical mobility care plan instructed staff "Wheelchair use, wheelchair is provided by hospice, staff to propel resident. " Intake of unsafe food related to speech therapy recommended diet pureed pudding thicken liquids care plan diet waiver signed allowing mechanical soft honey thickened liquids as evidenced by coughing with meals , resident needing staff supervision with meals and speech therapy recommendations for staff and resident to follow with each meal. Recommendations from speech therapy not on the care plan. The Care plan did not address wheel chair positioning for meals.

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F 309	Continued From page 33 On 11/2/16, at 7:20 a.m. R21 was in the dining room sitting in a low Broda chair. The back of chair was partially reclined back about 15 degrees from upright. There were no foot rests on chair, R21's feet were dangling just above the ground. The table top was at R21's nipple line. R21 was wearing blue anti slip socks. -7:30 a.m. the DNS walked through the dining room. -8:20 a.m. staff placed breakfast of scrambled eggs, waffles, and oatmeal in front of R21. Wheel chair position unchanged. -8:32 a.m. R21 was observed to be coughing and choking. NA-A and LPN-D came to R21's table and stayed with R21 until he was able to clear his throat. LPN-D reminded R21 to "swallow before putting another bite in your mouth" Broda chair remained reclined 15 degrees with table top at mid chest level. -8:51 a.m. R21 had a moist cough strong enough to cause R21 to pull legs part way to his chest. -8:59 a.m. NA-A rolled R21 out of the dining room with feet dangling above the ground about an inch. The OT-Therapist Progress & Discharge Summary dated 1/2/14, indicated, "Issued 18" [inch] wide x 16" deep,14" seat to floor height, 13" high right arm rest, 16" seat back, Ischial step cushion with slight saddle-wheelchair has allowed for pt [patient] to have increased stability at hips and solid heel contact needed for self-propelling and to reduce risk for falls from wheelchair. Facilitated and provided graded assistance for wheelchair mobility from appropriate 14" floor to seat wheelchair. Assessed and provided feedback during meals with 14" floor to seat wheelchair. Facilitated and provided graded cueing during activities and exercises to increase	F 309		

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heel contact needed for increased independence with wheelchair mobility." Requested most current wheelchair positioning assessment, no other wheelchair positioning assessments provided.

During interview on 11/3/16, at 11:39 a.m. the DNS stated she expected staff to ensure residents would be positioned properly and would not be sliding repeatedly or leaning in their wheel chairs. DNS stated expected staff to ensure proper body alignment in the wheelchair and that the residents were sitting upright while eating.

During interview on 11/3/16, at 1:38 p.m. LPN-D said R21 coughed all the time. His family had signed a diet wavier for quality of life. Hospice was aware of the coughing. LPN-D said, "I did not notice [R21's] chair was reclined at breakfast yesterday. Today his chair was reclined so I lifted his chair upright. [R21] should be sitting upright for meals and the table should be lowered to the right height so he can feed himself."

During interview on 11/3/16, at 4:29 p.m. OT-B said hospice usually provides the Broda chairs. Therapy saw R21 on 1/2/14, for positioning. R21 was in a 16 inch wide wheel chair and the seat was 14 inch from the floor (a standard wheel chair was 16 inches). At that time R21 was self-propelling the wheelchair. OT-B stated if residents were not self-propelling a wheel chair than the residents feet should be supported. "We did not do a wheelchair assessment for the Broda chair."

R100's quarterly MDS dated 9/15/16, indicated R100 was severely cognitively impaired, rarely understood others and had severely impaired

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vision. R100's MDS indicated R100 was dependent on staff for all activities of daily living, and was incontinent of bowel and bladder. R100's MDS indicated R100 was on hospice and had diagnoses of dementia, hypertension anxiety and depression. Progress note dated 10/26/16, indicated R100 had a stage two pressure ulcer.

Pressure Ulcer CAA dated 12/31/15, indicated R100 was totally dependent on staff for transfers using a mechanical lift, and needed a special seat cushion in wheelchair to reduce or relieve pressure

Alteration in skin integrity care plan printed 11/3/16, instructed staff to provide pressure reducing wheelchair cushion and turn and reposition according to schedule and as needed.

On 11/02/16, at 7:20 a.m. unidentified NA brought R100 into the main dining room. R100 was sitting slouched down in Broda chair. R 100's incontinence product was sticking out of the pants and R100's abdomen was exposed. R100's legs were falling outward to the left and right. R100's right shoulder was higher than left and R100 was leaning to the left in the Broda chair.
-7:30 a.m. the DNS walked through dining room and stopped and spoke to R100.
-7:40 a.m. LPN-C adjusted R100's shirt so the incontinence product not seen.
-8:07 a.m. R100 in same position with intermittent crying. R100's shoulders still angled to the left and knees falling outwards with feet on foot rest
-8:09 a.m. NA-D spoke with R100 and applied a clothing protector.
-8:22 a.m. LPN-D sat down to feed R100 without adjusting R100's position.
-9:01 a.m. LPN-D wheeled R100 out of the dining

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GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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room.
-9:06 a.m. NA-A brought mechanical; lift into R100's room to transfer R100 to bed. R100 crying.

OT-Therapist Progress & Discharge Summary dated 11/21/14, indicated, "Significant progress demonstrated with safe sitting in customized wheelchair during meals. Functional progress this week has been significant due to issued personalized/customized 18" wide kyphotic wheelchair back, 5 degree dump slight saddle pressure relieving cushion with armrest bolsters and elevated right armrest, lateral trunk supports, calf pad and foot rests in order to decrease risk of falls and increase comfort during meals." Requested most current wheelchair positioning assessment, no other wheelchair positioning assessments provided.

During interview on 11/2/16, at 9:13 a.m. NA-A said R100 should have been repositioned during breakfast because she looked uncomfortable.

During follow up interview on 11/3/16, at 10:04 a.m. NA-A said, "When [R100] cries she will move down in the chair. [R100] is turned and repositioned every two hours."

During interview on 11/3/16, at 11:39 a.m. DNS stated expected staff to ensure residents would be positioned properly and would not be sliding repeatedly or leaning in their wheel chairs. DNS stated expected staff to ensure proper body alignment in the wheelchair and that the residents were sitting upright while eating.

During interview on 11/3/16, at 1:26 p.m. LPN-D said R100 was contracted as her legs do not

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extend out. When the legs are placed in the extension mode R100 would contract them right back up. LPN-D said, "Usually we use the side bolster but it does not work well so sometimes we use a pillow to keep her from falling to the left."

During interview on 11/3/16, at 4:29 p.m. OT-B said hospice usually provides the Broda chairs. Therapy saw R100 in November 2014. She was placed in an 18 inch kyphotic high back wheelchair and had a saddle cushion, lateral trunk supports and calf pads for her legs. OT-B was unable to say when R100's customized wheelchair was replaced with a Broda chair. "We did not do a wheelchair assessment for the Broda chair."

Wheel chair positioning policy requested. Facility provided Wheelchair use of procedure dated 2/26/16. Procedure indicated the purpose was to provide mobility for the non-ambulatory resident with safety and comfort. Procedure instructed staff that "Many types of wheelchairs are available. Follow the manufacturer's instructions for each type of wheelchair." The policy further instructed staff to "Lower foot rest and place feet on the foot rests if used. Position feet and legs in good body alignment." The procedure did not address upper body alignment or assessment for appropriate type or size of wheelchair.

Broda Seating Operating Manual dated 11/5/09, instructs facility staff "BRODA chairs are intended exclusively for residents of long-term care institutions who are under the care of professional caregivers. The suitability of a BRODA chair must be determined by a qualified caregiver who is familiar with the seating needs of the intended resident. Any other use of the chair is excluded

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F 309	Continued From page 38 from possible liability claims." "2.6 Improper Use As outlined, the improper use of the chair is dangerous to the resident, caregivers, or third parties, and can consist of, but is not limited to the following: 1) Unauthorized operation of the chair's functions. 2) Unauthorized movement of the chair. 3) Inappropriate use of the chair for a resident who has not been assessed by a qualified caregiver responsible for their seating. 4) Failure to frequently reposition the resident in the chair." The repositioning policy was requested but not provided.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance for 1of 1 resident (R28) reviewed for activities of daily living who required assistance with shaving. Findings include: During random observation on 10/31/16, at 1:42 p.m. R28 was observed to have black facial hair on right edge of mouth. On 11/1/16, at 12:23 p.m. black facial hair remains on R28 right side of mouth.	F 311	The resident, R28, has had facial hair removed. All residents residing in the facility will have facial hair removed unless resident preference states other wise. All nursing staff have been re-educated on the requirement to remove facial hair from all residents unless the resident preference states otherwise. Monitoring to ensure compliance will be conducted through weekly grooming audits.	12/13/16

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F 311	Continued From page 39 On 11/3/16, at 7:19 a.m. nursing assistant (NA)-C changed R28's incontinence product assisted R28 to get dressed and wash face. NA-C combed R28's hair. NA-C took R28 to a table in small dining room for breakfast. R28 had eight black 1/2 inch long hairs on the right side of mouth. On 11/3/16, at 9:05 a.m. NA-C took R28 to room and performed incontinence cares. When NA-C was done R28 still had approximately eight black 1/2 inch hairs on the right side of mouth. R28's activities of daily living Care Area assessment dated 4/6/16, indicated R28 required assistance with grooming. R28's quarterly MDS dated 9/14/16, indicated R28 was severely cognitively impaired with diagnosis of dementia, depression, and chronic pain. R28's MDS indicated R28 required assistance with personal hygiene including shaving. R28's physical functioning deficit care plan printed 11/3/16, instructed staff to assist R28 with personal hygiene. During interview on 11/3/16, at 7:21 a.m. when R28 was asked about facial hair, R28 replied, "A lady does not have facial hair. Do I have facial hair?" During interview on 11/3/16, at 9:58 a.m. NA-C said, " She accepts and appreciates help. I did not shave her today. I was so busy. She has a little mustache. I normally shave her after one to two days depending on the beard. We are to look every morning when she gets up and shave her if	F 311	The facility QAPI committee will review the grooming audits quarterly for further recommendations. The date of completion will be 12-13-16.	

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F 311	Continued From page 40 needed. I should have done so today."	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assist a resident to the toilet who was dependent on staff for toileting for 1 of 4 (R52) residents observed during observation for wheelchair positioning. Findings include: R52 was continuous observation on 11/2/16, from 7:20 a.m. until 11:57a.m. and the following noted: On 11/2/16, at 7:20 a.m. R52 was in the dining room reading the newspaper. R52 was slouched part way down in Broda chair, with knees above the top of the table. R52's feet were on foot pedals. -7:44 a.m. registered nurse (RN)-K with Asera Care hospice took R52 out of the dining room. -7:55 a.m. RN-K returned R52 to the dining room table and gave R52 a magazine. -8:24 a.m. Breakfast placed in front of R52. R52 had not left the dining room since 7:44 a.m. -9:03 a.m. licensed practical nurse (LPN)-D wheeled R52 to the small dining room and positioned him at a table. - 9:50a.m. RN-D wheeled R52 back to the main	F 312	The resident, R52, has received toileting in accordance with plan of care. All residents residing in the facility will be toileted in accordance with their plan of care. All nursing staff have been re-educated on the requirement to toilet all residents in accordance with their plan of care. Monitoring to ensure compliance will be conducted through weekly observational audits of toileting to ensure accordance to the plan of care. The facility QAPI committee will review the observational toileting audits quarterly for further recommendations. The date of completion will be 12-13-16.	12/13/16

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dining room for an activity.
-10:52 a.m. R52 sitting in chair playing cards. Position unchanged with R52 slouched down in the chair. R52 remained in the dining room and had not left the area.
-10:55 a.m. activities assistant-A moved R52 to the parachute group and had R52 hold on to strap of the parachute.
-11:16 a.m. LPN-C was interviewed as to how frequently R52 was to be toileted and repositioned out of the Broda chair. LPN-C said, "[R52] gets checked and changed every two hours I will have to ask the nursing assistants when he was last changed."
-11:27 a.m. NA-A brought R52 to room and left room to locate a lift and sling.
-11:30 a.m. NA-A returned and said needed to wait for a lift as they only had one lift.
-11:34 a.m. LPN-C entered room and obtained permission to observe cares.
-11:36 a.m. NA-A and NA-B entered with a mechanical lift.
-11:38 a.m. NA-A and NA-B left to get EZ stand because R52 was an EZ stand transfer.
-11:39 a.m. NA-A and NA-B washed hands and put gloves on. NA-A explained to R54 what they were doing. NA-A and NA-B put on EZ stand belt and lifted R52 to a standing position and took R52 into the bathroom. NA-B pulled down R52's pants and removed the urine soaked incontinent brief. NA-B indicated the pad was very wet. NA-A and NA-B lowered R52 to the toilet seat and washed their hands. Staff exited the bathroom to allow R52 privacy.

R52's significant change of condition Minimum Data Set (MDS) dated 9/6/16, indicated R52 had both short and long term memory problems and diagnoses of dementia, osteoarthritis, hemiplegia

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(loss of movement on one side of the body) and failure to thrive. R52's MDS indicated R52 required assistance with dressing toileting, transfers and bed mobility and was always incontinent of bowel and bladder. R52's MDS identified R52 was at risk for skin breakdown and skin was intact.

R52's urinary incontinence Care Area Assessment (CAA) dated 4/15/16, indicated R52 was dependent on staff for toileting and was at risk for moisture related skin break down. Pressure ulcer CAA dated 4/15/16, indicated R52 was at risk for worsening skin break down and pressure ulcers. The Care Area Assessment for most recent MDS dated 9/6/16, were requested but not provided.

R52's self-care deficit care plan instructed staff on 9/21/16 to toilet R52 every two hours
During survey process R52's alteration in skin integrity related to impaired physical mobility, bowel and bladder incontinence presence of scrotal edema and at risk for scrotum shearing care plan was initiated.

During interview on 11/2/16, at 11:23 a.m. LPN-C said, "[NA-B] is at lunch. I am going to have it done right now since I assume it should have been done [regarding toileting of R52]. They should have done it after breakfast."

During interview 11/2/16, at 11:48 a.m. NA-B said, "I have not toileted him since before breakfast he is to be toileted every two hours. "

During interview with DNS and ADNS on 11/3/16, at 11:39 am DNS said they met with NA-B and NA-B admitted he had missed checking R52

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F 312	Continued From page 43 when he should have. Toileting and repositioning policies requested but not provided.	F 312		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was stored and prepared under sanitary conditions including: food preparation equipment was not maintained in good repair, refrigerator temperatures were not appropriately monitored to ensure safe food storage in 2 of 6 kitchenettes, and an ice machine in 1 of 6 kitchenettes was not maintained in a sanitary manner. This had the potential to affect 103 of 106 residents in the facility who received their meals from the kitchen areas. Findings include: On 10/31/16, at 7:02 a.m. during the initial kitchen tour, a Hobart large mixing bowl was observed on the counter of the back kitchen preparation area	F 371	The splash guard accessory on the Hobart mixer has been removed from the mixer. The door seal on the refrigerator in the 2 East main dining room has been repaired and is intact. The 2 East main dining room refrigerator was reloaded properly and is now maintaining proper temperatures below 41 degrees. The 1W main dining room refrigerator has been reloaded properly and is now maintaining proper temperatures, below 41 degrees. The ice machine spout in the 2 East main dining room has been cleaned and sanitized. The ice packs have been removed from the freezer section of the refrigerators in the 1 East main dining room, the 2 East main dining room and the internet caf¿ refrigerators.	12/13/16

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F 371	Continued From page 44 by the wall. The stainless steel mixing bowl was observed attached to the machine and a hard clear plastic splash guard was in place on the rim of the mixing bowl. The plastic splash guard attached to the bowl was observed to be cracked and broken and appeared brittle to touch. The assistant dietary manager was interviewed and verified the plastic splash guard was broken but was still being used for food preparation. When asked how long the splash guard had been like that, the assistant dieteary manager stated, "honestly I have not been looking." On 10/31/16, at 2:14 p.m. a follow up kitchen tour was completed with the dietary manager (DM) and the DM was asked about the broken plastic splash guard on the mixing bowl. The DM stated this had been reported and a new splash guard would be re-ordered. On 11/03/16, at 4:49 p.m. during interview with the executive director (ED), the ED stated she had not been aware the splash guard was broken however, when it was brought to her attention she'd asked the DM to remove it from the kitchen and to have it replaced. The facility's undated policy Maintaining Dietary Equipment directed: "The dietary equipment should be maintained for the health and safety of the residents and associates..." Kitchenettes 2 North Main dining room During a tour on 10/31/16, at 7:28 a.m. the 2 North main dining room refrigerator door bottom seal was observed to be stained black and hanging loose below the door. The thermometer indicated the temperature was	F 371	All food preparation equipment is in good repair. All refrigerators in the kitchenettes are maintained at temperatures below 41 degrees. All food items have been removed from kitchenette refrigerators upon expiration. All ice machine spouts and trays are clean and sanitary. All ice packs are stored in medication room freezers and not stored in kitchenette freezers. All dietary staff have been re-educated on the requirement to have all food preparation equipment in good repair and to immediately notify the dietary manager of any required repairs. All dietary staff have also been re-educated on the requirement to log refrigerator temperatures on the kitchenette refrigerators and to immediately report any temperatures above 41 degrees to the dietary manager. The dietary staff have also been re-educated on the requirement to remove all food items from the kitchenette refrigerators immediately upon expiration. All housekeeping staff have been re-educated on the requirement to properly clean and sanitize the ice machine spouts and trays as per schedule. The dietary staff and nursing staff have been re-educated on the requirement to store ice packs in the medication room freezers and not in the freezers in the kitchenettes which contain food items. Monitoring to ensure compliance will be conducted through weekly audits of all kitchen food preparation equipment to ensure all equipment is in proper working condition. Daily audits will be conducted of	

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F 371	Continued From page 45 50 degrees Fahrenheit. During a tour with the dietician on 10/31/16, at 8:03 a.m. the dietician verified the temperature in the refrigerator was 51 degrees and that there were four cartons of milk and seven boxes of thickened juice and two boxes of thickened milk also stored in the refrigerator. On 10/31/16, at 8:28 a.m. nursing assistant (NA)-B verified giving R30 nectar thick apple juice and milk from the refrigerator. NA-B verified giving R21 nectar thick water and milk, and R56 and R52 honey thick apple juice and milk from the refrigerator. 11/02/16, continuous observation from 7:18 a.m. until 8:15 a.m. included: -7:18 a.m. licensed practical nurse (LPN)-C verified refrigerator temp 15 degrees Celsius or 59 degrees Fahrenheit. -7:48 a.m. no one had entered refrigerator since 7:18 a.m. temperature 52 degrees. There were two cartons of thickened milk, two half gallons of white milk and one half gallon of chocolate milk. there are several thickened fruit juices cartons, three pitchers of juice and several individual containers of yogurt in the refrigerator. -7:59 a.m. dietary aide (DA)-A opened the refrigerator door and closed it. When asked the temperature of the fridge the DA-A said 40 degrees when shown the thermometer said it was 40 then asked to check again said it was 50 degrees. -8:03 a.m. cook-A came up and checked the refrigerator temperature and said it was 55 degrees. Cook-A stated, "I am going to remove everything and have maintenance come right up."	F 371	kitchenette refrigerators to ensure the refrigerators are being maintained at temperatures below 41 degrees, contain no expired food items and do not have ice packs stored in the freezer. Weekly audits will be conducted of all ice machines to ensure machine components are clean. The facility QAPI committee will review the kitchen and refrigerator audits quarterly for further recommendations. The date of completion will be 12-13-16.	

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F 371	Continued From page 46 Cook-A removed all food items from the refrigerator -8:15:45 AM maintenance-A arrived to look at fridge. 2 North Small dining room During initial tour on 10/31/16, at 7:33 a.m. there was an open yogurt that was labeled as having been open 10/26/16. During tour with the dietician on 10/31/16, at 8:08 a.m. the dietician verified that based on the date of open, the yogurt should have been thrown after three days. 1 West Main dining room At 7:02 a.m. on 10/31/16, the 1 West main dining room refrigerator temperature was observed to be 50 degrees. In the refrigerator there was a container of potato salad dated 10/24/16, eight pitchers of various juices, one box of nectar thick milk, two nectar apple and cranberry juice. During tour with the dietician on 10/31/16, at 7:57 a.m. the dietician verified the refrigerator temperature was 62 degrees. The dietician stated there is a risk of food born illness with the temperature this high. 2 East Main dining room During tour with the dietician on 10/31/16, at 8:13 a.m. the dietician verified the ice machine's ice spout was soiled, black in color and was potentially unsafe. During observation on 11/02/16, at 7:15 a.m. ice machine spout was still soiled black. There was no sign on the machine to indicate the machine should not be used. During a follow up tour on 11/03/16 at 12:41 p.m. with the dietician and dietary manager, the ice	F 371		

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GOLDEN LIVINGCENTER - HOPKINS	**725 SECOND AVENUE SOUTH HOPKINS, MN 55343**

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F 371	Continued From page 47 machine spout was still observed to be soiled black. A sign indicated the machine should not be used. During the observation, the Dietary Manager wiped some of the black substance off the spout and stated, "It is a mixture of lime, bicarb and build up of other unknown substance." The dietician stated, "I put the sign up yesterday when I noticed it had still not been cleaned. I had notified maintenance on Monday to take care of it." On 10/31/16, at 8:14 a.m. the dietician stated the refrigerator temperatures should be below 40 degrees and above freezing. If the temperature is not maintained in that range there is high risk of food borne illness from temperature sensitive foods like milk and potato salad or thickened juice because of risk for bacterial growth. Dietician stated food should be dated when opened and yogurt was good for three days after being opened. On 10/31/16, at 8:28 a.m. NA-B said, "I did not check the temperature before I removed the milk and juice to give them to residents." On 11/2/16, at 1:55 p.m. maintenance-A said the temperature was set on the warmest setting so I increased it to the coolest and tightened the door handle. I did check the coils and they were okay. During interview on 11/03/16 at 12:24 p.m. the executive director said she expected refrigerator temperatures to be within normal guidelines per regulation. ED stated she expect staff were responsible for monitoring the temperatures to notify the dining service director or maintenance if they are too warm "Once those reports are made,	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. BUILDING ______ B. WING ______	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HOPKINS	**725 SECOND AVENUE SOUTH HOPKINS, MN 55343**

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F 371	Continued From page 48 it comes to me and then we talk about how those issues are corrected." ED further stated "I was informed on Monday that there were some issues with refrigerator temps. I would not expect the issues to continue. If there is an issue I would expect that to be fixed timely so we can continue service." During interview on 11/3/16, at 12:41 p.m. the dietician said she notified maintenance Monday about the warm refrigerator temperatures and removed the food on Monday and again on Wednesday for the refrigerator on 2 North. The facility's Storage of Refrigerated Foods policy dated 2011, directed the Dining Services Department to store refrigerated food at 41 degrees F [Fahrenheit] or below and in such manner as to prevent spoilage and contamination according to the policy guidelines and federal state and local regulations.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431		12/13/16

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F 431	Continued From page 49 applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications and biologicals were stored and disposed of properly in 3 of 3 medication rooms, and one medication cart reviewed for medication storage. Findings include: The 1 West Medication room had four open vials of Tuberculin (a medication to skin test for Tuberculosis) ready and stored for use. One vial had an unreadable date when opened. Three vials were open but undated. It was unclear why the facility had four vials of Tuberculin open at the same time. The 1 East medication refrigerator had an expired	F 431	The tuberculin vials currently in use in the facility are properly dated when opened and disposed of properly when expired. All medications requiring disposal are disposed properly. All multi-dose medications are properly dated when opened and are disposed of in accordance with expiration dates. All medications are disposed in the proper manner. All licensed nurses have been re-educated on the requirement to date all multi-dose medications when they are opened and dispose of medications in accordance with expiration dates. All licensed nurses have been re-educated on the proper methods to dispose of	

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F 431	Continued From page 50 vial of tuberculin that was open and dated expiration of 10/27/16 (the medication expired seven days before). The 2 East medication refrigerator had one vial of tuberculin that was open but undated. The facility Policy for Medication Storage in the Facility,Storage of Medications (section 4.1, page 3 or 3, date written 5/12) read: Section E, "When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. 1) "The nurse shall place a [Date Opened] sticker on the medication and enter the date opened and the [new date of expiration] (NOTE: the best sticker to affix contain both a "Date opened" and "expiration" notation line). The expiration date of the vial or container will be [30] days unless the manufacturer recommend another date or regulations/guidelines require differenent dating (see 11.21- MEDICATIONS WITH SHORTENED EXPIRATION DATES)." The facility failed to follow their policy on dating multi-dose medication vials. On 11/3/16, at 9:40 a.m. licensed practical nurse (LPN)-B was observed administering medication to R33. R33 was observed to swallow some medications, then spit a white round pill onto the floor approximately two feet in front of him. LPN-B then picked up the pill with her hand (no glove), returned to the medication cart and opened it (without performing hand hygiene). LPN-B matched the pill retrieved from the floor with Vitamin D, and poured two more into her hand, she picked up a white plastic spoon, and then paused and looked at surveyors. At this time one surveyor asked LPN-B if she usually did put medications into her hand. LPN-B stated "no"	F 431	non-narcotic medications in the medication receptacles in the medication rooms. Monitoring to ensure compliance will be conducted through weekly medication audits to ensure that multi-dose medications are properly dated when opened and disposed of when expired. The facility QAPI committee will review the medication audits quarterly for further recommendations. The date of completion will be 12-13-16.	

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F 431	Continued From page 51 then scooped up the three round white pills with the spoon and put them into the trash receptacle on the medication cart. On 11/3/16, at 2:23 p.m. RN-A stated LPN-B should not have put medications into her hand, if they were going to be given to a patient. RN-A also verified that medications should not be put into the garbage, but should have gone into medication disposal (medication waste bin) in the medication room. However RN-A felt she should check with the director of nursing services (DNS) before giving the final answer. LPN-B stated "I would only dispose of medication in the medication room disposal bin, if the patient had spit it onto the floor". -At 2:37 p.m. RN-A stated the DNS verified, "technically it should be [disposed of] in the orange bin, in the medication room." RN-A verified there was one orange medication disposal bin in each medication room. The Equipment and Supplies for Administering Medications policy revised 2014, indicated the following equipement and supplies should be acquired and maintained by the facility for the proper storage, preparation, and administration of medications: 10) Disposal container for medications, sharps, and biohazardous waste generated during medication administration.	F 431		
F 458 SS=C	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.	F 458		12/13/16

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F 458	Continued From page 52 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility did not provide 80 square feet per resident for rooms 141, 142, 143, 144, 146, 165, 171, 240, 258, 260, 264, 269, 271, and 277. Findings include: During the survey cares were observed in four of the 14 rooms with no concerns were noted in the delivery of care. During the survey from 10/31/16, through 11/3/16, no families had concerns related to size of room however, R11 in room 277 had concerns with the size of the room and when facility was notified R11 was moved to a different room. During the entrance conference on 10/31/16, at 8:20 a.m. the executive director stated she would provide a letter to request the waiver again which was provided the same day.	F 458	Golden Living Center Hopkins would like to request a waiver under F458 in regards to resident room size. The specific rooms to be included in this waiver are: 142, 144, 146, 240, 258, 260, 264, 269, 271, 277. The following rooms previously identified for the waiver have been private rooms: 141, 143, 165, 171. These rooms were constructed in 1955 and do not meet the current requirements for square footage in two bedrooms. There is no method available to increase the size of the rooms without causing hardship on the facility. Granting this waiver would not aversely affect the residents in the aforementioned rooms. The resident's health, treatments, comfort, safety and well-being will be maintained at the highest possible level. Currently there are no concerns or complaints from residents regarding their room size. The Executive Director is responsible for the correction and monitoring to prevent a reoccurrence of the deficiency.	
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced	F 465		12/13/16

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F 465	Continued From page 53 by: Based on observation, interview and document review, the facility failed to ensure a safe, functional, sanitary and comfortable environment which included 17 rooms and on the second floor (201, 202, 203, 204, 205, 207, 210, 211, 220, 222, 243, 254, 259, 260, 261, 262, 277) and the shared bathrooms within these rooms. Findings include: During the environmental tour on 11/3/16, at 1:25 p.m. with the executive director (ED), maintenence director (M-D), maintenance employee (M-A), the housekeeping manager (H-M) and executive director interns (ED-A and ED-B) the following observations were identified and confirmed by the ED and M-D: -Room 201- The bathroom door frame had jagged edges and scrapes along the door, plaster along the sink was exposed and the bathroom floor was sticky with urine. -Room 202-The floor was sticky with urine, the porcelein in the toilet was scratched. -Room 203-A large gouge was observed on the back of the room door. -Room 204-The door had large scratches along the egdes. -Room 205- The bathroom door had deep gouges and the lining on the back of the toilet was peeling off. The bathroom had a urine odor. -Room 207- The bathroom smelled of urine, the floor vinyl was coming up and there was a used	F 465	All door frames identified as scratched or gouged have been repaired. All areas identified as requiring plaster repair have been repaired. All bathroom floors identified as requiring additional cleaning have been stripped and cleaned. The floor replacement vendor has been contacted in order to schedule a time to replace the flooring that needs to be replaced. All toilets identified as requiring repair have been repaired. For all doors identified with gouges the facility has contacted a vendor to provide the facility with the necessary materials to repair the doors. Materials have been placed on order as of 12/6/16. Furniture identified as ripped has been removed from use. Wheelchair cushions and footrests identified have been reassessed and the materials for correction have been ordered. All door frames will be free of scratches and gouges. Wall plaster is in good repair in resident rooms and bathrooms. All bathroom floors are clean and vinyl will be replaced by floor replacement vendor. All toilets are clean and in functional order. All doors will be in good repair upon reception of materials needed to repair the doors. All furniture in resident rooms and lounges are free from rips in the fabric. All wheelchair cushions and foot rests have been assessed for needed repairs and materials have been ordered. The maintenance staff have been re-educated on the requirement to keep doors and door frames free of scratches and gouges, plaster in good repair, vinyl flooring in bathrooms in good repair, all	

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F 465	Continued From page 54 urinal with black substance on the sides of the urinal sitting on the back of the toilet. -Room 210- There were gouges out of the back of the bed room door and at the top of the door.. The floor was stained in the bathroom. A facility chair in the room was ripped and the cushion was exposed. -Room 211- Plaster was exposed coming up along the back of the wall and edge of the toilet and the doors in the bathroom were scraped. -Room 220 The room and bathroom had a strong urine odor, the bathroom door had several scratched areas and there was black staining around the edges of the toilet. -Room 222-There were large gouges in the bathroom door and the porcelain had worn away on the toilet. The wall was scraped, exposing plaster by the head of the bed in the bedroom. The room smelled of body odor. -Room 243- The toilet cover did not fit the toilet in the bathroom. -Room 254-The linoleum was coming up in the bathroom and confirmed by the Administrator as a trip hazard. -Room 259-The wheelchair cushions were cracked and cushion was exposed on the wheelchair cushion and foot rests. -Room 262-The floor was sticky in the bathroom and there was a strong urine odor. -Room 277- The bathroom smelled of urine and	F 465	toilets in functional order, furniture free from ripped fabric and wheelchair cushions and parts in good repair. All housekeeping staff have been re-educated on the requirement to keep all bathroom floors clean and odor free. Monitoring to ensure compliance will be conducted through weekly environmental audits checking door frames, doors, room plaster, bathroom floor sanitation and repair, furniture repair and wheelchair cushions and parts for good repair. The facility QAPI committee will review the environmental audits quarterly for further recommendations. The date of completion will be 12-13-16.	

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	245293	A. BUILDING ______ B. WING ______	C **11/03/2016**

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F 465	Continued From page 55 there were gouges on the bathroom wall exposing plaster.	F 465		

F5293025

APPROVED By Tom Linhoff at 1:18 pm, Jan 05, 2017

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/30/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245293	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 11/01/2016

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K 000 INITIAL COMMENTS

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on November 01, 2016. At the time of this survey, Golden LivingCenter Hopkins was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145, or

K 000

K 000

Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in the Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations.

Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Executive Director

(X6) DATE: 12/8/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1	K 000		

By E-Mail to:
Marian.Whitney@state.mn.us and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

The original building was built in 1958, is two-stories, has no basement, is fully fire sprinkler protected and is of Type II(222) construction;
The 1st Addition was built in 1960, is two-stories, has no basement, is fully fire sprinkler protected and is of Type II(222) construction;
The 2nd Addition was built in 1965, is two-stories, has no basement, is fully fire sprinkler protected and is of Type II(222) construction;
The 3rd Addition was built in 1989, is two-stories, has no basement, is fully fire sprinkler protected and is of Type II(222) construction;
The 4th Addition was built in 1993, is two-stories, has no basement is fully fire sprinkler protected and is of Type II(222) construction;

The facility has a fire alarm system with smoke detection in the corridors and spaces open to corridors which is monitored for automatic fire department notification. The facility has a capacity of 138 beds and had a census of 106 at

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K 000	Continued From page 2 the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000	K 352	
K 352 SS=F	NFPA 101 Sprinkler System - Supervisory Signals Sprinkler System - Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility did not install automatic sprinkler system supervisory attachments in accordance with NFPA 72, National Fire Alarm and Signaling Code, that are displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. NFPA 72, 9.7.2.1. This deficient practice could affect all 108 residents. Findings Include: On a facility tour between the hours of 1100 and 1500 on November 01, 2016, observation revealed that the facility does not have a remote fire alarm annunciator panel installed in a area that is continuously supervised by staff. This deficient practice was verified by the	K 352	The facility will contact the company that provides service to the fire sprinkler system to ensure that the annunciator panel is ordered to be installed in a location that is monitored by staff continuously throughout all three shifts. The facility currently has an annunciator panel at the front entrance of the building that is in working order and will continue to have the panel in use in addition to the new panel that will be installed in the new location. Staff will be re-educated to ensure that they understand the use of the current annunciator panel when the fire alarm system is activated. The Director of Maintenance will ensure that the annunciator panel is installed and in proper working order and will monitor through random audits. The facility QAPI committee will review the audits for further recommendations. Date completed by: 12/13/16	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 352	Continued From page 3 Maintenance Director at the time of inspection.	K 352		
K 712 SS=C	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility could not provide documentation that fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2012 NFPA 101, Section 19.7.1.4. through 19.7.1.7. This deficient practice could affect all 106 residents. Findings include: On a facility tour between the hours of 1100 and 1500 on November 01, 2016, observation revealed that the facility could not provide documentation for completing a fire drill for the first and third shifts during the first quarter of 2016.	K 712	K 712 Fire drills will be conducted on the first and third shift and properly documented in order to ensure that accurate documentation is reflected. The maintenance staff has been educated to ensure that all fire drills are documented appropriately. Monitoring to ensure compliance will be conducted by the Maintenance Director or designee through audits to ensure that that documentation of the fire drills are in place. The facility QAPI committee will review the audits for further recommendations. Date completed by: 12/13/16	

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	245283	A. BUILDING 01 - MAIN BUILDING 01 B. WING ________	11/01/2016

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K 712	Continued From page 4 This deficient practice was verified by the Administrator at the time of inspection.	K 712		

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
November 30, 2016

Ms. Talia Aramalay, Administrator
Golden LivingCenter - Hopkins
725 Second Avenue South
Hopkins, MN 55343

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5293027 and Complaint Numbers H5293055 and H5293058.

Dear Ms. Aramalay:

The above facility was surveyed on October 31, 2016 through November 3, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint numbers H5293055 and H5293058. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Gloria Derfus, Unit Supervisor at (651) 201-3792

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00872	A. BUILDING: ______ B. WING ______	C 11/03/2016

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: Minnesota Department of Health is documenting the State Licensing Correction Orders using the federal software. Tag numbers have been assigned to Minnesota state statutes/rules for nursing homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the	2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/09/16

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2 000	Continued From page 1 corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period for Correction. During the recertification survey on 10/31/16, through 11/3/16, complaint investigation(s) were conducted at the time of the standard survey. An investigation of complaint, H5293055 was completed. The complaint was substantiated. Deficiency(ies) issued at 0265 and 1810. The complaint was substanitated. Deficiency(ies) issued at 1805, F0915 and 1655. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's	2 265		12/13/16

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2 265	Continued From page 2	2 265		

legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for:

A. an accident involving the resident which results in injury and has the potential for requiring physician intervention;

B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications;

C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;

D. a decision to transfer or discharge the resident from the nursing home; or

E. expected and unexpected resident deaths.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to ensure the resident's representative was notified when medications changed and change in condition for 1 of 1 resident (R191) reviewed for notification of change.

Provider's plan of correction: Corrected

Findings include:

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2 265	Continued From page 3 R191's diagnoses included unspecified dementia without behavioral disturbance, hypothyroidism, acute kidney failure and repeated falls obtained from the Admission Record dated 4/26/16. During review of the interdisciplinary team (IDT) note dated 1/27/16, it was revealed resident had edema (swelling) on both lower extremities, some redness on the right inner thigh and resident had been started on a new order for Lasix 20 milligram (mg) by mouth every morning for three days for edema. During review of the interdisciplinary team (IDT) progress notes dated 1/7/16, through 1/29/16, it was revealed the medical record lacked documentation the wife or legal representative had been notified of the change in condition and R191's new treatment plan. R191's care plan dated 1/11/16, indicated resident had a diagnosis of Alzheimer's or related dementia, due to cognitive loss, had diminished decision making capabilities and as a result resident resided in the secured Alzheimer's Care Unit (ACU). R191's cognitive loss/dementia Care Area Assessment (CAA) dated 1/20/16, indicated resident had dementia and had a supportive family. On 11/3/16, at 7:28 a.m. licensed practical nurse (LPN)-C verified resident had been started on Lasix on 1/26/16, however the medical record lacked documentation the wife or the legal representative had not been notified of the treatment changes and the change in condition.	2 265		

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2 265	Continued From page 4	2 265		

On 11/3/16, at 7:35 a.m. the director of nursing services (DNS) stated she would have expected the staff nurse to document resident family had been notified of any changes in treatment which included the medications. DNS verified the medical record lacked documentation the wife or legal representative had been notified of the change in condition and treatment plan.

On 11/3/16, at 7:50 a.m. via a telephone conversation a family member stated they were not pleased with the care during the brief time R191 was in the facility. Family member indicated during one visit to the facility had noticed "his feet were swollen like a balloon. I think he needed Lasix. I was never notified of any medication changes." Family member indicated she was R191's legal representative and was supposed to be told.

The facility Notification of Change in Resident Health Status policy dated 10/12/16, directed "The center will consult the resident's physician, nurse practitioner or physician assistant, and if known notify the resident's legal representative or an interested family member when there is:
(A) An accident which results in injury and has the potential for requiring physician intervention.

Notification: Within 24 hours from the time as assessment has been made indicating there may be a potential for physician intervention.

(B) Acute illness or a significant change in the resident's physical, mental, or psychosocial status (i.e. deterioration in health, mental, psychosocial status in either life-threatening conditions or clinical complications.)

(C) A need to alter treatment significantly (i.e. a

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2 265	Continued From page 5 need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment)..." Your Rights Under The Combined Federal and Minnesota Residents Bill of Rights dated July 1,2007, provided to resident and legal representative directed "14. Notice of Changes in Your Condition. The facility must consult with you immediately when there is an accident involving. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop policies and procedures to ensure each resident's representative is promptly notified of all changes in condition and/or changes in treatments. The DON or designee could educate all appropriate staff on the policies/procedures, and monitor to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days.	2 265		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the plan of care was implemented for shaving for 1 of 3 residents (R28) reviewed for activities of daily	2 565	Corrected	12/13/16

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2 565	Continued From page 6 living (ADLs), failed to assist 1 of 2 residents (R52) to the toilet in accordance with their toileting plan, and failed to prevent non-pressure related skin break down related to lack of repositioning and shearing for 1 of 4 residents (R52) reviewed for wheelchair positioning. Findings Include: R28 was observed on 10/31/16 at 1:42 p.m., to have black facial hair on the right edge of her mouth. On 11/1/16, at 12:23 p.m. the black facial hair remained on the right side of R28's mouth. On 11/3/16, at 7:19 a.m. nursing assistant (NA)-C was observed to assist R28 with adl's. NA-C changed R28's incontinence product, then assisted R28 to get dressed, wash face and comb the resident's hair. NA-C then took R28 to a table in the small dining room for breakfast. At that time, R28 was observed to have eight black 1/2 inch long hairs on the right side of her mouth. On 11/3/16, at 9:05 a.m. NA-C was obsesrved to provide person hygiene care, incontinence care for R28. The NA did not identify or assist R28 with removal of the black 1/2 inch hairs on the right side of her mouth. R28's care plan identified interventions for staff to assist R28 with personal hygiene. During interview on 11/3/16, at 7:21 a.m. when R28 was asked about facial hair, R28 replied, "A lady does not have facial hair. Do I have facial hair?" During interview on 11/3/16, at 9:58 a.m. NA-C said, "She accepts and appreciates help. I did not shave her today. I was so busy. She has a little	2 565		

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2 565	Continued From page 7	2 565		

mustache. I normally shave her after one to two days depending on the beard. We are to look every morning when she gets up and shave her if needed. I should have done so today."

R52 was observed on 11/2/16, at 7:20 a.m. in the dining room reading the newspaper. R52 was slouched part way down in Broda chair, with knees above the top of the table. R52's hips were at approximately 45 degree angle with knees higher than hips. R52's feet were on foot pedals.
Additional observations on 11/2/16 included:
-7:30 a.m. the director of nursing services (DNS) walked through the dining room and spoke with other residents.
-7:32 a.m. nursing assistant (NA)-A offered R52 a clothing protector. NA-A did not adjust R52's wheelchair positioning.
-7:44 a.m. registered nurse (RN)-K with Asera Care hospice took R52 out of the dining room.
-7:55 a.m. RN-K returned R52 to the dining room table and gave R52 a magazine. R52's knees remained higher than the table top.
-8:14 a.m. R52 pushed himself-back from the dining room table.
-8:21 a.m. RN-K checked R52's foot rest and adjust his feet.
-8:24 a.m. Breakfast meal was placed in front of R52. NA-A adjusted R52's chair so R52's knees were not above the table top.
-9:03 a.m. licensed practical nurse (LPN)-D wheeled R52 to the small dining room and positioned him at a table. R52 was positioned upright at the table with both knees lying to the left the table top.
- 9:05 a.m. R51. RN-D reclined Broda chair part way without telling R52 she was going to recline him. R52's eyes went wide open and R52 opened his mouth wide and upper body stiffened. RN-D wheeled R52 to the main dining room.

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2 565	Continued From page 8 -9:54 a.m. R52 was sitting in Broda chair at table playing cards by his self. R52 was sliding part way down in chair. The Broda chair was in an upright position. -10:52 a.m. R52 sitting in chair playing cards. Position unchanged with R52 slouched down in the chair. -10:55 a.m. activities assistant-A moved R52 to the parachute group and had R52 hold on to strap of the parachute. -11:16 a.m. LPN-C was interviewed as to how frequently R52 was to be toileted and repositioned out of the Broda chair. LPN-C said, "[R52] gets checked and changed every two hours I will have to ask the nursing assistants when he was last changed." - 11:23 a.m. LPN-C said, "[NA-B] is at lunch. I am going to have it done right now since I assume it should have been done. They should have done it after breakfast." -11:27 a.m. NA-A brought R52 to room and left room to locate a lift and sling. -11:28 a.m. surveyor obtained R52's permission to observe cares. -11:30 a.m. NA-A returned and said needed to wait for a lift as they only had one lift. -11:34 a.m. LPN-C entered room and obtained permission to observe cares -11:36 a.m. NA-A and NA-B entered with mechanical lift. -11:38 a.m. NA-A and NA-B left to get EZ stand because R52 was an EZ stand transfer. -11:39 a.m. NA-A and NA-B washed hands and put gloves on. NA-A explained to R54 what they were doing. NA-A and NA-B put on EZ stand belt and lifted R52 to a standing position and took R52 into the bathroom. NA-B pulled down R52's pants and removed the soiled incontinent brief. NA-B indicated the pad was very wet with urine. NA-A and NA-B lowered R52 to the toilet seat and	2 565		

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2 565	Continued From page 9	2 565		

washed their hands. Staff exited the bathroom to allow R52 privacy.
- 11:48 a.m. NA-B said, "I have not noticed him sliding down in the chair. I have not toileted him since before breakfast he is to be toileted every two hours.
-11:49 a.m. LPN-C checked R52's bottom when he was standing in the EZ Stand. Red bloody area noted on scrotum. LPN-C asked NA-A and NA-B to put R52 in bed and then go get RN-D to assess and measure the wound.
At 11:57 a.m. RN-D measured the wound on R52's scrotum and stated it was 1.5 centimeters (cm.) long by x 0.5 cm. wide. RN-D said the depth was too shallow to measure. RN-D and LPN-C said that was a new wound and they were going to call it a Stage two pressure ulcer (Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister) due to prolong sitting and R52 sliding in the Broda chair.

R52's OT-Therapist Progress & Discharge Summary dated 7/29/15, indicated, "Provided caregiver education on recommendations for wch [wheelchair] in upright alignment, Repositioning of hips in wch every 1-2 hours due to pt [patient] unable to initiate secondary to cognitive impairment and recommendation for leisure activities out in front of pt on tables to reduce agitation."

R52's Swallowing Difficulty as related to Abnormal Swallow study care plan dated 10/6/15, instructed staff to ensure proper positioning at meals. R52's self-care deficit care plan instructed staff on 9/21/16, to toilet R52 every two hours. During the survey process alteration in skin integrity related to impaired physical mobility, bowel and bladder

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2 565	Continued From page 10	2 565		

incontinence presence of scrotal edema and at risk for scrotum shearing care plan were initiated.

R52's significant change of condition Minimum Data Set (MDS) dated 9/6/16, indicated R52 had both short and long term memory problems and diagnoses of dementia, osteoarthritis, hemiplegia (loss of movement on one side of the body) and failure to thrive. R52's MDS indicated R52 required assistance with dressing toileting, transfers and bed mobility and was always incontinent of bowel and bladder. R52's MDS identified R52 was at risk for skin breakdown and skin was intact.

The Treatment Administration Record dated 11/1/16 through 11/30/16, indicated R52 was to be repositioned every two hours and as needed. The date of the order was 4/9/15.

During an interview 11/2/16, at 2:03 p.m. LPN-C said, "We reassessed the wound with the assistant director of nursing (ADNS) and the wound is caused by shearing and is not a pressure ulcer. The treatment will be barrier cream, off loading/reposition every hour. I have ordered a low air loss mattress. We believe the shearing was caused when they transferred [R52] with the EZ stand." LPN-C said "We did considered the sliding in the Broda chair and high knees as possible causes of shearing and have requested hospice have their Physical Therapist evaluate him for positioning."

During interview on 11/3/16, at 10:04 a.m. NA-A said, "[R52] tries to move sometimes when he is in pain or is wet. If he was at the table with his knees above the table we should have sat him up after we boosted him up in the chair."

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2 565	Continued From page 11 During interview with DNS and ADNS on 11/3/16, at 11:39 a.m. DNS said they met with NA-B and NA-B had admitted he had missed checking R52 when he should have. The DNS said, "He felt it was not deliberate but I did report it to OHFC (the Office of Health Facility Complaints) and suspended NA-B until we complete the investigation, because it could be construed as neglect under the vulnerable adult act. The ADNS said, "I went and reassessed with our RN clinical educator and LPN-C. We reassessed R52 right after lunch. The RN clinical educator and I determined it looked more like a shearing traumatic injury. R52 is in a reclining wheel chair and his scrotum is quite edematous and large." The ADNS said, "He slid down during the transfer and then standing with the standing lift. Because it was such frank blood we feel it occurred during the transfer." The DNS also confirmed the ADNS is not wound certified nor is the RN clinical educator. The DNS stated she expected staff to ensure residents would be positioned properly and would not be sliding repeatedly or leaning in their wheelchairs. The DNS further stated she expected staff to ensure residents were sitting upright while eating. During interview on 11/3/16, at 1:29 p.m. LPN-D said, "R52 sits forward a lot. He almost looks like he is trying to pull himself forward." During interview on 11/3/16, at 4:29 p.m. occupational therapist (OT)-B said hospice usually provided the Broda chairs. OT-B also stated therapy had seen R52 in July of 2015, for positioning. "We recommended frequent repositioning of hips as needed." OT-B said, "It would not be appropriate to have R52's knees above the table."	2 565		

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2 565	Continued From page 12 SUGGESTED METHOD OF CORRECTION: The director of nursing could re-educate all staff to follow care plans in regards to specific resident cares and services, and could develop a system to audit and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 4 of 4 residents (R56, R52, R21, R100) were appropriately evaluated for wheelchair positioning needs reviewed for positioning. In addition, the facility failed to ensure 1 of 4 residents (R52) maintained intact skin. Findings include:	2 830	Corrected	12/13/16

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2 830	Continued From page 13	2 830		

R56's diagnoses included vascular dementia, major depressive disorder, hemiplegia and hemiparesis obtained from the Admission Record dated 11/3/16.

R56's quarterly Minimum Data Set (MDS) dated 5/18/16, indicated resident had both short and long term memory problems, had functional limitation of range motion to both lower extremities and used a wheelchair for mobility. Activities of daily living Care Area Assessment (CAA) dated 12/15/15, indicated R56 needed total assistance for transfers and locomotion due to dementia, impaired balance and history of cerebrovascular accident (CVA) with mobility deficits. Care plan dated 8/13/16, indicated R56 was at risk for physical functioning deficit related to cognitive impairment related to secondary vascular dementia. The care plan indicated resident used a wheelchair and staff was to keep the wheelchair in a reclined position until food was served at all meals. Care plan however, did not address the wheelchair positioning.

On 11/2/16, at 7:20 a.m. R56 was observed in the large dining room slouched part way down in high back tilt in space wheelchair. R56's body angled from left to right with legs dangled to right side off wheelchair.
-At 7:30 a.m. the director of nursing services (DNS) walked through the dining room adjusted R56's glasses, spoke briefly to resident and left never offered to adjust resident position.
-At 7:32 a.m. nursing assistant (NA)-A approached resident at the dining table offered a clothing protector however, never offered to adjust resident position even though the legs were still dangling.
-At 7:44 a.m. to 8:06 a.m. resident remained in the same position seated on wheelchair several

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2 830	Continued From page 14 staff in the area none offered to position resident. -At 8:20 a.m. R56 was still sitting angled left to right feet dangling off the right side of wheelchair and a plate of food was in front resident on the table. -At 8:29 a.m. NA-A and NA-B approached resident pulled resident chair back from table, cued resident then reclined wheelchair and lifted resident up in the wheelchair with a hand under arm and knee on each side. During the observation, the wheelchair was set back up footrest was not extended and resident feet were dangling. -At 8:55 a.m. NA-A approached R56 reclined the Broda wheelchair to a 45 degrees angle then put the footrest down, put resident feet on it and wheeled resident out of room in a 45 degree reclining. -At 9:38 a.m. resident was observed asleep at the end of the hall across from small dining room reclined at 45 degrees legs dangling off to the right and registered nurse (RN)-D walked past resident never offered to re-position resident. -At 9:43 a.m. the activities assistant walked past resident never offered to re-position. -At 9:43 a.m. licensed practical nurse (LPN)-C approached R56 and offered resident to go to bed. LPN-C stated she was going to adjust feet however left the feet still dangling and resident hips were observed off center to the right. -At 9:51 a.m. LPN-C returned with NA-A and NA-D wheeled resident into the room. On 11/3/16, at 9:17 a.m. R56 was observed seated on the Broda wheelchair in the room watching television. The wheelchair was slightly tilted at approximately 30 degrees, and resident bottom was slumped down on the wheelchair seat close to the edge, legs hanging to the right side of the folded footrest.	2 830		

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2 830	Continued From page 15 -At 9:20 a.m. NA-A and NA-C came into the room acknowledged resident was sliding out of the wheelchair and indicated that was why they needed to lay resident down. Both NA's indicated resident always did slide down the wheelchair and the nurses knew about it and thought the facility had tried three different wheelchairs with resident however still was sliding down. On 11/3/16, at 9:34 a.m. the occupational therapist (OT)-A reviewed the medical record and indicated the last time resident had been seen by OT-A was in 8/10/16, for a broken wheelchair. OT-A verified there was no notes or order were in the medical record for the need to do a full assessment for proper positioning. On 11/3/16, at 3:47 a.m. the director of rehabilitation stated resident was discharged from occupational therapy last in 10/20/14, and was on the same wheelchair and the recommendation was to reposition as needed and staff was to lay resident down if restless. The director of rehabilitation indicated, "we do quarterly screens to identify a change and if we identified a significant change we then would ask the doctor for orders to treat [R56]." The director of rehabilitation further stated she was not able to locate the quarterly screening for R56 from March this year however was going to check with medical records. On 11/3/16, at 4:18 p.m. LPN-C state R56 had been seen for a broken wheelchair armrest not positioning. LPN-C acknowledged R56 did dangle his feet on the side and stated the staff were supposed to reposition resident. LPN-C verified the care plan did not address the positioning and stated she would be obtaining an order for occupational therapy to evaluate R56 for	2 830		

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2 830	Continued From page 16 positioning. On 11/3/16, at 4:45 p.m. the director of rehabilitation verified there was no quarterly occupational therapy screens completed for R56 for wheelchair positioning. She indicated moving forward she would ensure quarterly screens were done consistently to make sure the residents were properly positioning in the wheelchairs. Souther, Glenora R52 was observed on 11/2/16, at 7:20 a.m. and was in the dining room reading the newspaper. R52 was slouched part way down in Broda chair, with knees above the top of the table top. R52's hips were at approximately 45 degree angle with knees higher than hips. R52's feet were on foot pedals. -7:30 a.m. the DNS walked through the dining room and spoke with other residents and did not adjust R52's wheelchair positioning. -7:32 a.m. NA-A offered R52 a clothing protector. NA-A did not adjust R52's wheelchair positioning. -7:44 a.m. registered nurse (RN)-K with Asera Care hospice took R52 out of the dining room. -7:55 a.m. RN-K returned R52 to the dining room table and gave R52 a magazine. R52's knees were higher than the table top. -8:14 a.m. R52 pushed self-back from dining room table. -8:21 a.m. RN-K checked R52's foot rest and adjust his feet. -8:24 a.m. Breakfast was placed in front of R52. NA-A adjusted R52's chair so R52's knees were not above the table top. -9:03 a.m. LPN-D wheeled R52 to the small dining room and positioned him at a table. R52 was positioned upright at the table with both	2 830		

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2 830	Continued From page 17 knees lying to the left the table top. - 9:R51. RN-D reclined Broda chair part way without telling R52 she was going to recline him. R52's eyes went wide open and R52 opened his mouth wide and upper body stiffened. RN-D wheeled R52 to the main dining room. -9:54 a.m. R52 was sitting in Broda chair at table playing cards by his self. R52 was sliding part way down in chair. The Broda chair was in an upright position. -10:52 a.m. R52 sitting in chair playing cards and the position was unchanged as R52 was slouched down in the chair. -10:55 a.m. activities assistant-A moved R52 to the parachute group and had R52 hold on to strap of the parachute. -11:16 a.m. LPN-C was interviewed as to how frequently R52 was to be toileted and repositioned out of the Broda chair. LPN-C said, "[R52] gets checked and changed every two hours I will have to ask the nursing assistants when he was last changed." -11:27 a.m. NA-A brought R52 to room and left room to locate a lift and sling. -11:30 a.m. NA-A returned and said needed to wait for a lift as they only had one lift. -11:36 a.m. NA-A and NA-B entered with a mechanical lift. -11:38 a.m. NA-A and NA-B left to get EZ stand because R52 was an EZ stand transfer. -11:39 a.m. NA-A and NA-B washed hands and put gloves on. NA-A explained to R54 what they were doing. NA-A and NA-B put on EZ stand belt and lifted R52 to a standing position and took R52 into the bathroom. NA-B pulled down R52's pants and removed the soiled incontinent brief. NA-B indicated the pad was very wet. NA-A and NA-B lowered R52 to the toilet seat and washed their hands. Staff exited the bathroom to allow R52 privacy.	2 830		

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2 830	Continued From page 18	2 830		

-11:49 a.m. LPN-C checked R52's bottom when he was standing in the EZ Stand. There was a red bloody area noted on scrotum. LPN-C asked NA-A and NA-B to put R52 in bed and then go get RN-D to assess and measure the wound.
At 11:57 a.m. RN-D measured the wound on R52's scrotum and stated it was 1.5 centimeters (cm.) long by x 0.5 cm. wide. RN-D said the depth was too shallow to measure. RN-D and LPN-C said that was a new wound and they were going to call it a stage two pressure ulcer (partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present) due to prolong sitting and R52 sliding in the Broda chair.

R52's significant change of condition MDS dated 9/6/16, indicated R52 had both short and long term memory problems and diagnoses of dementia, osteoarthritis, hemiplegia (loss of movement on one side of the body) and failure to thrive. R52's MDS indicated R52 required assistance with dressing toileting, transfers and bed mobility and was always incontinent of bowel and bladder. R52's MDS identified R52 was at risk for skin breakdown and skin was intact.

R52's urinary incontinence CAA dated 4/15/16, indicated R52 was dependent on staff for toileting and was at risk for moisture related skin break down. The pressure ulcer CAA dated 4/15/16, indicated R52 was at risk for worsening skin break down and pressure ulcers. The Care Area Assessment for the most recent comprehensive MDS dated 9/6/16, were requested but not provided.

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2 830	Continued From page 19	2 830		

R52's Swallowing Difficulty as related to Abnormal Swallow study care plan dated 10/6/15, instructed staff to ensure proper positioning at meals. R52's self-care deficit care plan instructed staff on 9/21/16, to toilet R52 every two hours. During the survey process, the alteration in skin integrity related to impaired physical mobility, bowel and bladder incontinence, and the presence of scrotal edema and at risk for scrotum shearing care plan were initiated.

The Treatment Administration Record dated 11/1/16 through 11/30/16, indicated R52 was to be repositioned every two hours and as needed. The date of the order was 4/9/15.

The OT-Therapist Progress & Discharge Summary dated 7/29/15, indicated, "Provided caregiver education on recommendations for wch [wheelchair] in upright alignment, Repositioning of

hips in wch every 1-2 hours due to pt [patient] unable to initiate secondary to cognitive impairment and recommendation for leisure activities out in front of pt on tables to reduce agitation."

During interview on 11/02/16 at 11:23 a.m. LPN-C said, "[NA-B] is at lunch. I am going to have it done right now since I assume it should have been done. They should have done it after breakfast."

During interview 11/2/16, at 11:48 a.m. NA-B said, "I have not noticed him sliding down in the chair. I have not toileted him since before breakfast he is to be toileted every two hours.

During interview 11/2/16, at 2:03 p.m. LPN-C

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2 830	Continued From page 20	2 830		

said, "We reassessed the wound with the assistant director of nursing (ADNS) and the wound is caused by shearing and is not a pressure ulcer. The treatment will be barrier cream, off loading/reposition every hour. I have ordered a low air loss mattress. We believe the shearing was caused when they transferred [R52] with the EZ stand." LPN-C said "We did considered the sliding in the Broda chair and high knees as possible causes of shearing and have requested hospice have their physical therapist evaluate him for positioning."

During interview on 11/3/16, at 10:04 a.m. NA-A said, "[R52] tries to move sometimes when he is in pain or is wet. If he was at the table with his knees above the table we should have sat him up after we boosted him up in the chair."

During interview with DNS and ADNS on 11/3/16, at 11:39 a.m. DNS said they met with NA-B and NA-B had admitted he had missed checking R52 when he should have. The DNS said, "He felt it was not deliberate but I did report it to OHFC (the Office of Health Facility Complaints) and suspended NA-B until we complete the investigation, because it could be construed as neglect under the vulnerable adult act. The ADNS said, "I went and reassessed with our RN clinical educator and LPN-C. We reassessed R52 right after lunch. The RN clinical educator and I determined it looked more like a shearing traumatic injury. R52 is in a reclining wheel chair and his scrotum is quite edematous and large." The ADNS said, "He slid down during the transfer and then standing with the standing lift. Because it was such frank blood we feel it occurred during the transfer." The DNS also confirmed the ADNS is not wound certified nor is the RN clinical

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2 830	Continued From page 21	2 830		

educator. The DNS stated she expected staff to ensure residents would be positioned properly and would not be sliding repeatedly or leaning in their wheelchairs. The DNS further stated she expected staff to ensure residents were sitting upright while eating.

During interview on 11/3/16, at 1:29 p.m. LPN-D said, "R52 sits forward a lot. He almost looks like he is trying to pull himself forward."

During interview on 11/3/16, at 4:29 p.m. occupational therapist (OT)-B said hospice usually provided the Broda chairs. OT-B also stated therapy had seen R52 in July of 2015, for positioning. "We recommended frequent repositioning of hips as needed." OT-B said, "It would not be appropriate to have R52's knees above the table."

R21's quarterly MDS dated 8/1/16, indicated R21 was severely cognitively impaired, sometimes understood others, and was dependent on staff for transfers, bed mobility, dressing, toileting, personal hygiene and wheel chair mobility. R21 required supervision when eating. R21's MDS indicated R21's diagnoses were dementia, chronic kidney disease, depression, anxiety, chronic obstructive pulmonary disease and experienced coughing/choking during meals. R21 was on hospice.

Pressure Ulcer CAA dated 2/25/16, indicated R21 required assistance with transfers and wheelchair mobility needed a special seat cushion in wheelchair to reduce or relieve pressure

Pressure ulcer actual or at risk care plan printed 11/3/16, instructed staff to provide pressure reducing wheelchair cushion and turning and

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GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

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2 830	Continued From page 22	2 830		

repositioning per assessment. Potential for impaired physical mobility care plan instructed staff "Wheelchair use, wheelchair is provided by hospice, staff to propel resident. " Intake of unsafe food related to speech therapy recommended diet pureed pudding thicken liquids care plan diet waiver signed allowing mechanical soft honey thickened liquids as evidenced by coughing with meals , resident needing staff supervision with meals and speech therapy recommendations for staff and resident to follow with each meal. Recommendations from speech therapy not on the care plan. The Care plan did not address wheel chair positioning for meals.

On 11/2/16, at 7:20 a.m. R21 was in the dining room sitting in a low Broda chair. The back of chair was partially reclined back about 15 degrees from upright. There were no foot rests on chair, R21's feet were dangling just above the ground. The table top was at R21's nipple line. R21 was wearing blue anti slip socks.
-7:30 a.m. the DNS walked through the dining room.
-8:20 a.m. staff placed breakfast of scrambled eggs, waffles, and oatmeal in front of R21. Wheel chair position unchanged.
-8:32 a.m. R21 was observed to be coughing and choking. NA-A and LPN-D came to R21's table and stayed with R21 until he was able to clear his throat. LPN-D reminded R21 to "swallow before putting another bite in your mouth" Broda chair remained reclined 15 degrees with table top at mid chest level.
-8:51 a.m. R21 had a moist cough strong enough to cause R21 to pull legs part way to his chest.
-8:59 a.m. NA-A rolled R21 out of the dining room with feet dangling above the ground about an inch.

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The OT-Therapist Progress & Discharge Summary dated 1/2/14, indicated, "Issued 18" [inch] wide x 16" deep,14" seat to floor height, 13" high right arm rest, 16" seat back, Ischial step cushion with slight saddle-wheelchair has allowed for pt [patient] to have increased stability at hips and solid heel contact needed for self-propelling and to reduce risk for falls from wheelchair. Facilitated and provided graded assistance for wheelchair mobility from appropriate 14" floor to seat wheelchair. Assessed and provided feedback during meals with 14" floor to seat wheelchair. Facilitated and provided graded cueing during activities and exercises to increase heel contact needed for increased independence with wheelchair mobility." Requested most current wheelchair positioning assessment, no other wheelchair positioning assessments provided.

During interview on 11/3/16, at 11:39 a.m. the DNS stated she expected staff to ensure residents would be positioned properly and would not be sliding repeatedly or leaning in their wheel chairs. DNS stated expected staff to ensure proper body alignment in the wheelchair and that the residents were sitting upright while eating.

During interview on 11/3/16, at 1:38 p.m. LPN-D said R21 coughed all the time. His family had signed a diet wavier for quality of life. Hospice was aware of the coughing. LPN-D said, "I did not notice [R21's] chair was reclined at breakfast yesterday. Today his chair was reclined so I lifted his chair upright. [R21] should be sitting upright for meals and the table should be lowered to the right height so he can feed himself."

During interview on 11/3/16, at 4:29 p.m. OT-B said hospice usually provides the Broda chairs.

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2 830	Continued From page 24 Therapy saw R21 on 1/2/14, for positioning. R21 was in a 16 inch wide wheel chair and the seat was 14 inch from the floor (a standard wheel chair was 16 inches). At that time R21 was self-propelling the wheelchair. OT-B stated if residents were not self-propelling a wheel chair than the residents feet should be supported. "We did not do a wheelchair assessment for the Broda chair." R100's quarterly MDS dated 9/15/16, indicated R100 was severely cognitively impaired, rarely understood others and had severely impaired vision. R100's MDS indicated R100 was dependent on staff for all activities of daily living, and was incontinent of bowel and bladder. R100's MDS indicated R100 was on hospice and had diagnoses of dementia, hypertension anxiety and depression. Progress note dated 10/26/16, indicated R100 had a stage two pressure ulcer. Pressure Ulcer CAA dated 12/31/15, indicated R100 was totally dependent on staff for transfers using a mechanical lift, and needed a special seat cushion in wheelchair to reduce or relieve pressure Alteration in skin integrity care plan printed 11/3/16, instructed staff to provide pressure reducing wheelchair cushion and turn and reposition according to schedule and as needed. On 11/02/16, at 7:20 a.m. unidentified NA brought R100 into the main dining room. R100 was sitting slouched down in Broda chair. R 100's incontinence product was sticking out of the pants and R100's abdomen was exposed. R100's legs were falling outward to the left and right. R100's right shoulder was higher than left and R100 was	2 830		

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2 830	Continued From page 25 leaning to the left in the Broda chair. -7:30 a.m. the DNS walked through dining room and stopped and spoke to R100. -7:40 a.m. LPN-C adjusted R100's shirt so the incontinence product not seen. -8:07 a.m. R100 in same position with intermittent crying. R100's shoulders still angled to the left and knees falling outwards with feet on foot rest -8:09 a.m. NA-D spoke with R100 and applied a clothing protector. -8:22 a.m. LPN-D sat down to feed R100 without adjusting R100's position. -9:01 a.m. LPN-D wheeled R100 out of the dining room. -9:06 a.m. NA-A brought mechanical; lift into R100's room to transfer R100 to bed. R100 crying. OT-Therapist Progress & Discharge Summary dated 11/21/14, indicated, "Significant progress demonstrated with safe sitting in customized wheelchair during meals. Functional progress this week has been significant due to issued personalized/customized 18" wide kyphotic wheelchair back, 5 degree dump slight saddle pressure relieving cushion with armrest bolsters and elevated right armrest, lateral trunk supports, calf pad and foot rests in order to decrease risk of falls and increase comfort during meals." Requested most current wheelchair positioning assessment, no other wheelchair positioning assessments provided. During interview on 11/2/16, at 9:13 a.m. NA-A said R100 should have been repositioned during breakfast because she looked uncomfortable. During follow up interview on 11/3/16, at 10:04 a.m. NA-A said, "When [R100] cries she will move down in the chair. [R100] is turned and	2 830		

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2 830	Continued From page 26	2 830		

repositioned every two hours."

During interview on 11/3/16, at 11:39 a.m. DNS stated expected staff to ensure residents would be positioned properly and would not be sliding repeatedly or leaning in their wheel chairs. DNS stated expected staff to ensure proper body alignment in the wheelchair and that the residents were sitting upright while eating.

During interview on 11/3/16, at 1:26 p.m. LPN-D said R100 was contracted as her legs do not extend out. When the legs are placed in the extension mode R100 would contract them right back up. LPN-D said, "Usually we use the side bolster but it does not work well so sometimes we use a pillow to keep her from falling to the left."

During interview on 11/3/16, at 4:29 p.m. OT-B said hospice usually provides the Broda chairs. Therapy saw R100 in November 2014. She was placed in an 18 inch kyphotic high back wheelchair and had a saddle cushion, lateral trunk supports and calf pads for her legs. OT-B was unable to say when R100's customized wheelchair was replaced with a Broda chair. "We did not do a wheelchair assessment for the Broda chair."

Wheel chair positioning policy requested. Facility provided Wheelchair use of procedure dated 2/26/16. Procedure indicated the purpose was to provide mobility for the non-ambulatory resident with safety and comfort. Procedure instructed staff that "Many types of wheelchairs are available. Follow the manufacturer's instructions for each type of wheelchair." The policy further instructed staff to "Lower foot rest and place feet on the foot rests if used. Position feet and legs in good body alignment." The procedure did not

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address upper body alignment or assessment for appropriate type or size of wheelchair.

Broda Seating Operating Manual dated 11/5/2009 instructs facility staff "BRODA chairs are intended exclusively for residents of long-term care institutions who are under the care of professional caregivers. The suitability of a BRODA chair must be determined by a qualified caregiver who is familiar with the seating needs of the intended resident. Any other use of the chair is excluded from possible liability claims."
"2.6 Improper Use
As outlined, the improper use of the chair is dangerous to the resident, caregivers, or third parties, and can consist of, but is not limited to the following:
1) Unauthorized operation of the chair's functions.
2) Unauthorized movement of the chair.
3) Inappropriate use of the chair for a resident who has not been assessed by a qualified caregiver responsible for their seating.
4) Failure to frequently reposition the resident in the chair."

The repositioning policy was requested but not provided.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing or her designee could develop polices and procedures regarding assessing and monitoring non-pressure related skin conditions and repostioning. The Director of Nursing or her designee could educate staff on the policies and procedures. The Director of Nursing or her designee could develop a monitoring system to ensue residents receive the appropriate care.

TIME FRAME FOR CORRECTION: Twenty One (21) Days.

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2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and	2 915		12/13/16
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assist a resident to the toilet who was dependent on staff for toileting for 1 of 4 (R52) residents observed during observation for wheelchair positioning. Findings include: R52 was continuous observation on 11/2/16, from 7:20 a.m. until 11:57a.m. and the following noted: On 11/2/16, at 7:20 a.m. R52 was in the dining room reading the newspaper. R52 was slouched part way down in Broda chair, with knees above the top of the table. R52's feet were on foot pedals.		Corrected	

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2 915	Continued From page 29	2 915		

-7:44 a.m. registered nurse (RN)-K with Asera Care hospice took R52 out of the dining room.
-7:55 a.m. RN-K returned R52 to the dining room table and gave R52 a magazine.
-8:24 a.m. Breakfast placed in front of R52. R52 had not left the dining room since 7:44 a.m.
-9:03 a.m. licensed practical nurse (LPN)-D wheeled R52 to the small dining room and positioned him at a table.
- 9:50a.m. RN-D wheeled R52 back to the main dining room for an activity.
-10:52 a.m. R52 sitting in chair playing cards. Position unchanged with R52 slouched down in the chair. R52 remained in the dining room and had not left the area.
-10:55 a.m. activities assistant-A moved R52 to the parachute group and had R52 hold on to strap of the parachute.
-11:16 a.m. LPN-C was interviewed as to how frequently R52 was to be toileted and repositioned out of the Broda chair. LPN-C said, "[R52] gets checked and changed every two hours I will have to ask the nursing assistants when he was last changed."
-11:27 a.m. NA-A brought R52 to room and left room to locate a lift and sling.
-11:30 a.m. NA-A returned and said needed to wait for a lift as they only had one lift.
-11:34 a.m. LPN-C entered room and obtained permission to observe cares.
-11:36 a.m. NA-A and NA-B entered with a mechanical lift.
-11:38 a.m. NA-A and NA-B left to get EZ stand because R52 was an EZ stand transfer.
-11:39 a.m. NA-A and NA-B washed hands and put gloves on. NA-A explained to R54 what they were doing. NA-A and NA-B put on EZ stand belt and lifted R52 to a standing position and took R52 into the bathroom. NA-B pulled down R52's pants and removed the urine soaked incontinent

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2 915	Continued From page 30	2 915		

brief. NA-B indicated the pad was very wet. NA-A and NA-B lowered R52 to the toilet seat and washed their hands. Staff exited the bathroom to allow R52 privacy.

R52's significant change of condition Minimum Data Set (MDS) dated 9/6/16, indicated R52 had both short and long term memory problems and diagnoses of dementia, osteoarthritis, hemiplegia (loss of movement on one side of the body) and failure to thrive. R52's MDS indicated R52 required assistance with dressing toileting, transfers and bed mobility and was always incontinent of bowel and bladder. R52's MDS identified R52 was at risk for skin breakdown and skin was intact.

R52's urinary incontinence Care Area Assessment (CAA) dated 4/15/16, indicated R52 was dependent on staff for toileting and was at risk for moisture related skin break down. Pressure ulcer CAA dated 4/15/16, indicated R52 was at risk for worsening skin break down and pressure ulcers. Care Area Assessment for most recent MDS dated 9/6/16, were requested but not provided.

R52's self-care deficit care plan instructed staff on 9/21/16 to toilet R52 every two hours
During survey process R52 ' s alteration in skin integrity related to impaired physical mobility, bowel and bladder incontinence presence of scrotal edema and at risk for scrotum shearing care plan was initiated.

During interview on 11/2/16, at 11:23 a.m. LPN-C said, "[NA-B] is at lunch. I am going to have it done right now since I assume it should have been done [regarding toileting of R52]. They should have done it after breakfast."

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2 915	Continued From page 31 During interview 11/2/16, at 11:48 a.m. NA-B said, "I have not toileted him since before breakfast he is to be toileted every two hours. " During interview with DNS and ADNS on 11/03/16 at 11:39 am DNS said they met with NA-B and NA-B admitted he had missed checking R52 when he should have. Toileting policies requested but not provided. SUGGESTED METHOD FOR CORRECTION: The DON or designee(s) could review and revise as necessary the policies and procedures regarding the need for assistance with toileting services. The DON or designee (s) could provide training for all appropriate staff on these policies and procedures and importance of documentation. The DON or designee (s) could monitor to assure all residents are receiving adequate and appropriate care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced	2 920		12/13/16

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2 920	Continued From page 32 by: Based on observation, interview and document review, the facility failed to provide assistance for 1of 1 resident (R28) reviewed for activities of daily living who required assistance with shaving. Findings include: During random observation on 10/31/16, at 1:42 p.m. R28 was observed to have black facial hair on right edge of mouth. On 11/1/16, at 12:23 p.m. black facial hair remains on R28 right side of mouth. On 11/3/16, at 7:19 a.m. Nursing assistant (NA)-C changed R28's incontinence product assisted R28 to get dressed and wash face. NA-C combed R28's hair. NA-C took R28 to a table in small dining room for breakfast. R28 had eight black 1/2 inch long hairs on the right side of mouth. On 11/3/16, at 9:05 a.m. NA-C took R28 to room and performed incontinence cares. When NA-C was done R28 still had approximately eight black 1/2 inch hairs on the right side of mouth. R28's activities of daily living Care Area assessment dated 4/6/16, indicated R28 required assistance with grooming. R28's quarterly MDS dated 9/14/16, indicated R28 was severely cognitively impaired with diagnosis of dementia, depression, and chronic pain. R28's MDS indicated R28 required assistance with personal hygiene including shaving. R28's physical functioning deficit care plan printed 11/3/16, instructed staff to assist R28 with personal hygiene.	2 920	Corrected	

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2 920	Continued From page 33 During interview on 11/3/16, at 7:21 a.m. when R28 was asked about facial hair, R28 replied, "A lady does not have facial hair. Do I have facial hair?" During interview on 11/3/16, at 9:58 a.m. NA-C said, " She accepts and appreciates help. I did not shave her today. I was so busy. She has a little mustache. I normally shave her after one to two days depending on the beard. We are to look every morning when she gets up and shave her if needed. I should have done so today." SUGGESTED METHOD OF CORRECTION: The director of nursing and or designee could ensure that residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 920		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was stored and prepared under sanitary conditions including: food preparation equipment was not	21015	Corrected	12/13/16

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21015	Continued From page 34	21015		

maintained in good repair, refrigerator temperatures were not appropriately monitored to ensure safe food storage in 2 of 6 kitchenettes, and an ice machine in 1 of 6 kitchenettes was not maintained in a sanitary manner. This had the potential to affect 103 of 106 residents in the facility who received their meals from the kitchen areas.

Findings include:

On 10/31/16, at 7:02 a.m. during the initial kitchen tour, a Hobart large mixing bowl was observed on the counter of the back kitchen preparation area by the wall. The stainless steel mixing bowl was observed attached to the machine and a hard clear plastic splash guard was in place on the rim of the mixing bowl. The plastic splash guard attached to the bowl was observed to be cracked and broken and appeared brittle to touch. The assistant dietary manager was interviewed and verified the plastic splash guard was broken but was still being used for food preparation. When asked how long the splash guard had been like that, the assistant dieteary manager stated, "honestly I have not been looking."

On 10/31/16, at 2:14 p.m. a follow up kitchen tour was completed with the dietary manager (DM) and the DM was asked about the broken plastic splash guard on the mixing bowl. The DM stated this had been reported and a new splash guard would be re-ordered.

On 11/03/16, at 4:49 p.m. during interview with the executive director (ED), the ED stated she had not been aware the splash guard was broken however, when it was brought to her attention she'd asked the DM to remove it from the kitchen and to have it replaced.

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21015	Continued From page 35 The facility's undated policy Maintaining Dietary Equipment directed: "The dietary equipment should be maintained for the health and safety of the residents and associates..." Souther, Glenora SUGGESTED METHOD FOR CORRECTION: The Administrator and the Dietician could review and revise food service policies and procedures to assure that food is served in a sanitary manner. Staff could be trained as necessary. The Certified Dietary Manager could monitor the service of food storage and preparation on a periodic basis. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21015		
21025	MN Rule 4658.0615 Food Temperatures Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade) or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure acceptable refrigerator temperatures were maintained to ensure the safe storage of beverages in 2 of 6	21025	Corrected	12/13/16

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21025	Continued From page 36 kitchenettes. This had the potential to affecct 26 out of 106 residents who utilized beverages from these refrigerators. Findings include: Kitchenettes 2 North Main dining room During a tour on 10/31/16, at 7:28 a.m. the 2 North main dining room refrigerator door bottom seal was observed to be stained black and hanging loose below the door. The thermometer indicated the temperature was 50 degrees Fahrenheit. During a tour with the dietician on 10/31/16, at 8:03 a.m. the dietician verified the temperature in the refrigerator was 51 degrees and that there were four cartons of milk and seven boxes of thickened juice and two boxes of thickened milk also stored in the refrigerator. On 10/31/16, at 8:28 a.m. nursing assistant (NA)-B verified giving R30 nectar thick apple juice and milk from the refrigerator. NA-B verified giving R21 nectar thick water and milk, and R56 and R52 honey thick apple juice and milk from the refrigerator. 11/02/16, continuous observation from 7:18 a.m. until 8:15 a.m. included: -7:18 a.m. licensed practical nurse (LPN)-C verified refrigerator temp 15 degrees Celsius or 59 degrees Fahrenheit. -7:48 a.m. no one had entered refrigerator since 7:18 a.m. temperature 52 degrees. There were two cartons of thickened milk, two half gallons of	21025		

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white milk and one half gallon of chocolate milk. there are several thickened fruit juices cartons, three pitchers of juice and several individual containers of yogurt in the refrigerator.
-7:59 a.m. dietary aide (DA)-A opened the refrigerator door and closed it. When asked the temperature of the fridge the DA-A said 40 degrees when shown the thermometer said it was 40 then asked to check again said it was 50 degrees.
-8:03 a.m. cook-A came up and checked the refrigerator temperature and said it was 55 degrees. Cook-A stated, "I am going to remove everything and have maintenance come right up." Cook-A removed all food items from the refrigerator
-8:15:45 AM maintenance-A arrived to look at fridge.

2 North Small dining room
During initial tour on 10/31/16, at 7:33 a.m. there was an open yogurt that was labeled as having been open 10/26/16. During tour with the dietician on 10/31/16, at 8:08 a.m. the dietician verified that based on the date of open, the yogurt should have been thrown after three days.

1 West Main dining room
At 7:02 a.m. on 10/31/16, the 1 West main dining room refrigerator temperature was observed to be 50 degrees. In the refrigerator there was a container of potato salad dated 10/24/16, eight pitchers of various juices, one box of nectar thick milk, two nectar apple and cranberry juice.

During tour with the dietician on 10/31/16, at 7:57 a.m. the dietician verified the refrigerator temperature was 62 degrees. The dietician stated there is a risk of food born illness with the temperature this high.

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2 East Main dining room

During tour with the dietician on 10/31/16, at 8:13 a.m. the dietician verified the ice machine's ice spout was soiled, black in color and was potentially unsafe.
During observation on 11/02/16, at 7:15 a.m. ice machine spout was still soiled black. There was no sign on the machine to indicate the machine should not be used.
During a follow up tour on 11/03/16 at 12:41 p.m. with the dietician and dietary manager, the ice machine spout was still observed to be soiled black. A sign indicated the machine should not be used. During the observation, the Dietary Manager wiped some of the black substance off the spout and stated, "It is a mixture of lime, bicarb and build up of other unknown substance." The dietician stated, "I put the sign up yesterday when I noticed it had still not been cleaned. I had notified maintenance on Monday to take care of it."

On 10/31/16, at 8:14 a.m. the dietician stated the refrigerator temperatures should be below 40 degrees and above freezing. If the temperature is not maintained in that range there is high risk of food borne illness from temperature sensitive foods like milk and potato salad or thickened juice because of risk for bacterial growth. Dietician stated food should be dated when opened and yogurt was good for three days after being opened.

On 10/31/16, at 8:28 a.m. NA-B said, "I did not check the temperature before I removed the milk and juice to give them to residents."

On 11/2/16, at 1:55 p.m. maintenance-A said the

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temperature was set on the warmest setting so I increased it to the coolest and tightened the door handle. I did check the coils and they were okay.

During interview on 11/03/16 at 12:24 p.m. the executive director said she expected refrigerator temperatures to be within normal guidelines per regulation. ED stated she expect staff were responsible for monitoring the temperatures to notify the dining service director or maintenance if they are too warm "Once those reports are made, it comes to me and then we talk about how those issues are corrected." ED further stated "I was informed on Monday that there were some issues with refrigerator temps. I would not expect the issues to continue. If there is an issue I would expect that to be fixed timely so we can continue service."

During interview on 11/3/16, at 12:41 p.m. the dietician said she notified maintenance Monday about the warm refrigerator temperatures and removed the food on Monday and again on Wednesday for the refrigerator on 2 North.

The facility's Storage of Refrigerated Foods policy dated 2011, directed the Dining Services Department to store refrigerated food at 41 degrees F [Fahrenheit] or below and in such manner as to prevent spoilage and contamination according to the policy guidelines and federal state and local regulations.

SUGGESTED METHOD OF CORRECTION: The RD or designee could develop policies and procedures to ensure potentially hazardous foods are held at the proper temperature to avoid food borne illness. The RD or designee could educate all appropriate staff on these policies and procedures. The RD or designee could develop

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21025	Continued From page 40 monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21025		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure symptom screens were completed for 2 of 5 employees (RN-C and NA-E) reviewed for Tuberculosis (TB).	21426	Corrected	12/13/16

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21426	Continued From page 41 Findings include: Registered nurse (RN)-C's employment record was reviewed and included a hire date of 9/20/16. RN-C's employment record did not include a symptom screen for TB. Nursing assistant (NA)-E's employment record was reviewed and included a hire date of 9/13/16. NA-E's employment record did not include a symptoms screen for TB. The human resources director (HRD) was interviewed on 11/3/16 at 10:35 a.m. confirmed RN-C and NA-E did not have symptom screens completed upon hire at the facility. The HRD went on to say that they complete symptom screens annually, and as RN-C and NA-E were new employees, they would not have had a symptom screen completed. On 11/13/16, at 2:35 p.m. the director of nursing services (DNS) confirmed all new employees should have a completed TB symptom screen completed. A policy was requested and the HRD indicated the facility used the "Regulations for Tuberculosis Control in Minnesota Health Care Settings" handbook dated July 2013. Review of the handbook indicated all newly hired employees should have documentation of a TB symptom screen. SUGGESTED METHOD OF CORRECTION: The infection control coordinator/nurse or designee could review the TB policies and procedures to ensure required information is included. Appropriate staff could be educated regarding requirements. Audits could be could be	21426		

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21426	Continued From page 42 conducted and the results reviewed at the quality committee meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications and biologicals were stored and disposed of properly in 3 of 3 medication rooms, and one medication cart reviewed for medication storage. Findings include: The 1 West Medication room had four open vials of Tuberculin (a medication to skin test for Tuberculosis) ready and stored for use. One vial had an unreadable date when opened. Three vials were open but undated. It was unclear why the facility had four vials of Tuberculin open at the same time. The 1 East medication refrigerator had an expired vial of tuberculin that was open and dated expiration of 10/27/16 (the medication expired seven days before). The 2 East medication refrigerator had one vial of	21610	Corrected	12/13/16

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tuberculin that was open but undated.

The facility Policy for Medication Storage in the Facility,Storage of Medications (section 4.1, page 3 or 3, date written 5/12) read:
Section E, "When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated.
1) "The nurse shall place a [Date Opened] sticker on the medication and enter the date opened and the [new date of expiration] (NOTE: the best sticker to affix contain both a "Date opened" and "expiration" notation line). The expiration date of the vial or container will be [30] days unless the manufacturer recommend another date or regulations/guidelines require differenent dating (see 11.21- MEDICATIONS WITH SHORTENED EXPIRATION DATES)."
.
The facility failed to follow their policy on dating multi-dose medication vials.

Wong, Becky
On 11/3/16, at 9:40 a.m. licensed practical nurse (LPN)-B was observed administering medication to R33. R33 was observed to swallow some medications, then spit a white round pill onto the floor approximately two feet in front of him. LPN-B then picked up the pill with her hand (no glove), returned to the medication cart and opened it (without performing hand hygiene). LPN-B matched the pill retrieved from the floor with Vitamin D, and poured two more into her hand, she picked up a white plastic spoon, and then paused and looked at surveyors. At this time one surveyor asked LPN-B if she usually did put medications into her hand. LPN-B stated "no" then scooped up the three round white pills with the spoon and put them into the trash receptacle

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on the medication cart.

On 11/3/16, at 2:23 p.m. RN-A stated LPN-B should not have put medications into her hand, if they were going to be given to a patient. RN-A also verified that medications should not be put into the garbage, but should have gone into medication disposal (medication waste bin) in the medication room. However RN-A felt she should check with the director of nursing services (DNS) before giving the final answer. LPN-B stated "I would only dispose of medication in the medication room disposal bin, if the patient had spit it onto the floor".
-At 2:37 p.m. RN-A stated the DNS verified, "technically it should be [disposed of] in the orange bin, in the medication room." RN-A verified there was one orange medication disposal bin in each medication room.

The Equipment and Supplies for Administering Medications policy revised 2014, indicated the following equipement and supplies should be acquired and maintained by the facility for the proper storage, preparation, and administration of medications:
10) Disposal container for medications, sharps, and biohazardous waste generated during medication administration.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure medications including vaccination solution, are appropriately stored and not expired. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing

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21610	Continued From page 45 compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	21610		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a safe, functional, sanitary and comfortable environment which included 17 rooms and on the second floor (201, 202, 203, 204, 205, 207, 210, 211, 220, 222, 243, 254, 259, 260, 261, 262, 277) and the shared bathrooms within these rooms. Findings include: During the environmental tour on 11/3/16, at 1:25 p.m. with the executive director (ED), maintenence director (M-D), maintenance employee (M-A), the housekeeping manager (H-M) and executive director interns (ED-A and ED-B) the following observations were identified and confirmed by the ED and M-D: -Room 201- The bathroom door frame had jagged edges and scrapes along the door, plaster along the sink was exposed and the bathroom floor was sticky with urine. -Room 202-The floor was sticky with urine, the	21665	Corrected	12/13/16

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21665	Continued From page 46 porcelein in the toilet was scratched. -Room 203-A large gouge was observed on the back of the room door. -Room 204-The door had large scratches along the egdes. -Room 205- The bathroom door had deep gouges and the lining on the back of the toilet was peeling off. The bathroom had a urine odor. -Room 207- The bathroom smelled of urine, the floor vinyl was coming up and there was a used urinal with black substance on the sides of the urinal sitting on the back of the toilet. -Room 210- There were gouges out of the back of the bed room door and at the top of the door.. The floor was stained in the bathroom. A facility chair in the room was ripped and the cushion was exposed. -Room 211- Plaster was exposed coming up along the back of the wall and edge of the toilet and the doors in the bathroom were scraped. -Room 220 The room and bathroom had a strong urine odor, the bathroom door had several scratched areas and there was black staining around the edges of the toilet. -Room 222-There were large gouges in the bathroom door and the porcelain had worn away on the toilet. The wall was scraped, exposing plaster by the head of the bed in the bedroom. The room smelled of body odor. -Room 243- The toilet cover did not fit the toilet in the bathroom.	21665		

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21665	Continued From page 47 -Room 254-The linoleum was coming up in the bathroom and confirmed by the Administrator as a trip hazard. -Room 259-The wheelchair cushions were cracked and cushion was exposed on the wheelchair cushion and foot rests. -Room 262-The floor was sticky in the bathroom and there was a strong urine odor. -Room 277- The bathroom smelled of urine and there were gouges on the bathroom wall exposing plaster. SUGGESTED METHOD OF CORRECTION: The DON or designee could educate staff and conduct periodic audits of areas residents frequent to ensure a safe and home like environment is obtained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21665		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide visual privacy	21805	Corrected	12/13/16

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	00872	A. BUILDING: ______ B. WING ______	C 11/03/2016

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GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

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21805	Continued From page 48	21805		

for 1 of 3 residents (R44) reviewed for urinary incontinence

Findings include:

During a random observation on 11/3/16, at 7:13 a.m. the door of the shower/tub room across from the nursing station was noted open. Nursing assistant (NA)-A requested something from licensed practical nurse (LPN)-D. Surveyor was able to see R44 seated on the toilet. R44's bare abdomen, left hip and left thigh were visible when standing outside the hallway. R44 was wearing a blue shirt pulled up and dark blue sweat pants were covering R44's feet lying on the floor in front of the toilet.

During observation on 11/3/16, at 9:45 a.m. R44 was brought to the shower/tub room across from the nurses' station. NA-A and NA-C verified there was no curtain around the toilet in the shower/tub room. At 9:51 a.m. NA-A and NA-c exited the shower room. Surveyor sitting at the nursing desk was able to see R44 sitting on the toilet. At 9:57 a.m. NA-A then entered the shower room and surveyor was able to see R44 sitting on the toilet with left side of body exposed.

R44's quarterly Minimum Data Set (MDS) dated 10/12/16, indicated R44 was severely cognitively impaired with verbal behaviors that affected others one to three days during the observational period. R44's MDS indicated R44 required assistance of two staff to use the toilet, and was frequently incontinent of bladder and always incontinent of bowel. In addition, R44's MDS indicated resident diagnoses included dementia and seizure disorder. R44's care plan dated 7/27/15, indicated R44 was incontinent of bowel and bladder and required assist of one to use the

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21805	Continued From page 49 toilet. During interview on 11/3/16, at 10:04 a.m. NA-A stated "we normally bring [R44] to the shower room because it is safer. [R44] can use the grab bars and can do the work himself." NA-A further stated, "There has never been a curtain around the toilet just in front of the shower. We try to be careful when we open the door but you can see into the room." On 11/3/16, at 3:58 p.m. family member (FM)-B stated, "He would be upset if someone could see him in the bathroom. If he were aware that someone could see him, he would tell them to get lost and close the door." During interview on 11/03/16, at 11:39 a.m. the director of nursing services (DNS) stated staff needed to maintain privacy for all residents. DNS further stated she was not aware that there was not a curtain in front of the toilet in the shower/tub room on the Alzheimer's unit as there had been one there. The facility Incontinence Care policy reviewed 1/26/15, directed staff to "Drape resident for privacy." The facility Dignity policy reviewed 3/31/16, indicated "All residents will be treated in a manner and in an environment that maintains and enhances each resident's dignity and respect in full recognition of his or her individuality. Treating residents with dignity and respect maintains and enhances each resident's self-worth and improves his or her psychosocial well-being and quality of life." Policy further instructed staff to maintain dignity by "Assisting residents in daily care in a dignified manner (e.g., pushing	21805		

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21805	Continued From page 50 residents forward in wheelchairs, covering appliances attached to resident, ensuring residents are not exposed)." SUGGESTED METHOD OF CORRECTION: The DON or designee could educate staff on dignity and respect. The DON or designee could then interview residents routinely to ensure residents feel their dignity and respect are being maintained. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21805		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure call lights were within at reach for 2 of 4 residents (R74, R54) who were at risk for falls during random observations. Findings include: R74's annual Minimum Data Set (MDS) dated	21810	Corrected	12/13/16

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21810	Continued From page 51 10/3/16, indicated R74 had severely impaired cognition and was able to understand others and make his needs understood. R74's MDS indicated resident needed assistance with all activities of daily living and diagnoses included paraplegia (paralysis), arthritis and Alzheimer's. During a random observation on 10/31/16, at 7:22 a.m. R74's call light was observed down the back of the bed. Registered nurse (RN)-D verified that call light was not within R74's reach. R74's fall Care Area Assessment (CAA) dated 10/18/16 indicated R74 was aware of what was being discussed but had problems with memory and recall. R74's alteration in elimination bowel and bladder care plan dated 9/22/12, instructed staff to ensure call bell within reach and provide reminders to use call bell as needed. Fall risk care plan initiated 9/22/16 instructed staff to have call light or personal items available and in easy reach or provide reacher. During interview on 10/31/16, at 7:22 a.m. RN-D stated R74 seldom used the call light. During interview on 10/31/16 at 7:26 a.m. nursing assistant (NA)-F said "oh yes [R74] can use his call light." R54's quarterly MDS dated 10/7/16, indicated R54 had moderately impaired cognition and was sometimes able to understand others and sometimes able to be understood. R54's MDS indicated R54 wanted an interpreter to communicate with health care staff. In addition the MDS indicated R54's diagnoses included low	21810		

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21810	Continued From page 52 back pain, atrial fibrillation, depression and anxiety and needed assistance with all activities of daily living. R54's vision CAA dated 1/25/16, indicated R54 was blind, had increased risk for falls and decline in activities of daily living. R54's care plan dated 1/22/15, indicated R54 was at risk for falls and instructed staff to have call light or personal items available and in easy reach. On 11/1/16, at 1:22 p.m. the director of social service (DSS) and surveyor entered R54 to set up an initial interview with R54 using the language line translator. DSS looked for the phone in R54's room but could not find it. DSS went and obtained a portable phone. R54's call light was observed lying on the floor next to R54's bed. R54 was lying in bed. DSS called R54's family on the phone and handed the phone to R54. DSS did not pick call light up and give it to R54. DSS had NA-F come to R54's room to see if R54 needed assistance. At 1:38 p.m. surveyor asked NA-F if R54 used the call light. NA-F verified R54 used the call light. NA-F did not check call light location prior to exiting the room. At 1:52 p.m. after completing interview with R54, surveyor put on the call light without moving it. NA-G answered the call light and verified call light was on the floor and out of R54's reach. NA-G gave the call light to R54. Call Light, Use of procedure reviewed 10/11/16, indicated the purpose was "to respond promptly to resident's call for assistance. To ensure call system is in proper working order. Procedure further instructs staff "when providing care to residents be sure to position the call light conveniently for the resident to use. Tell the resident where the call light was and show him/her how to use the call light. "Be sure all call	21810		

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21810	Continued From page 53 lights are placed on the bed at all times, never on the floor or bedside stand. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure call lights are kept within resident reach. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		